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SECOND ANNUAL REPORT—OPERATION OF MEDICARE PROGRAM

LETTER

FROM

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

TRANSMITTING

THE SECOND ANNUAL REPORT ON THE MEDICARE PROGRAM, PURSUANT TO SECTION 1875 (a) and (b) OF THE SOCIAL SECURITY ACT

JANUARY 20, 1969.—Referred to the Committee on Ways and Means and ordered to be printed with illustrations

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LETTER OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 17, 1969.

Hon. JOHN W. MCCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I have the honor to transmit to you the Medicare report which includes (1) my recommendations for legislation to improve the Medicare program, and (2) the second annual report on the operation of the Medicare program. Both were called for by the Congress in the Social Security Amendments of 1965. Section 1875 of the Social Security Act states:

"(a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged * * *

"(b) The Secretary shall make a continuing study of the operation and administration * * * and shall transmit to the Congress annually a report concerning the operation of such programs."

Medicare has done much to alleviate the financial burden of health care for nearly all of the aged residing in the United States. As of July 1, 1968, 19.7 million aged persons were entitled to hospital insurance protection and 18.8 million had elected to avail themselves of medical insurance protection. In the first 2 years of operation, almost $8.3 billion in benefits was paid by Medicare for services rendered to Medicare beneficiaries by providers of services, physicians, and suppliers. Overall, Medicare payments for hospital care and physicians' services are estimated to account for more than 70 percent of the expenditures (excluding expenditures of other public programs) for hospital care and physicians' services provided to the aged.

The program through its conditions of participation for providers of services assures that health facilities participating in the Medicare program meet professional standards of care and other requirements relating to the health and safety of patients. This reflects the fundamental principle that a purchaser of services on behalf of others must pursue more than just the fiscal interests of such individuals; it must assure that what it purchases is of the same quality that well-informed individuals would purchase for themselves. Medicare has been meeting this responsibility.

Part II of the enclosed report covers the administration of the Medicare program during its second year of operation—the fiscal year ending June 30, 1968. During the year substantial progress was made in several areas mentioned in the first annual report as warranting particular attention: assuring that adequate safeguards exist to prevent improper payment under the program and that the amounts paid are reasonable; assuring that providers maintain and continue to upgrade

the quality of their facilities in line with the conditions of participation in Medicare and that the conditions themselves remain responsive to contemporary standards in the health care field; bringing the utilization review committees that have been established by hospitals and extended care facilities to meet the requirements of Medicare up to their potential level of effectiveness in assuring appropriate utilization of health facilities; and improving beneficiary understanding of the program.

Along with its accomplishments, Medicare has brought into sharp focus the unprecedented rate at which medical care prices have increased over the last 3 years. This dramatic acceleration in medical care prices has become a source of considerable concern to all who are in any way affected. This concern has led to extensive discussion about the reasons for the increases and what steps might be taken to curb them.

The overall policies that have guided the activities of the Department of Health, Education, and Welfare in the health field are designed to meet the challenges of rising health care costs as well as to improve the quality and availability of health care in the United States. In light of these objectives Medicare and all other health related programs within the Department's jurisdiction must be continuously reexamined.

Experience in the almost 4 years since Medicare was enacted indicates the need for legislative changes in benefits, financing, and administration. In part I of the report, I am recommending specific changes which I believe will improve the Medicare program. In summary, the major recommendations are as follows:

1. Extend Medicare protection to disabled social security beneficiaries.
2. Cover certain maintenance drugs under Medicare.
3. Finance both hospital insurance and supplementary medical insurance through payroll contributions and general revenues.
4. Coordinate Federal reimbursement to health care facilities with State health facility planning.

I hope that the Congress will act favorably on these and my other recommendations because I believe the recommended changes are needed to enable the Medicare program to more fully realize its potential as a means of enhancing the quality of life for social security beneficiaries.

Sincerely,

WILBUR J. COHEN, *Secretary.*

REPORT ON MEDICARE

FROM

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

INCLUDING

RECOMMENDATIONS RELATING TO HEALTH CARE FOR THE AGED, PURSUANT TO SECTION 1875(a) OF THE SOCIAL SECURITY ACT, AND

THE SECOND ANNUAL REPORT ON THE OPERATION OF THE MEDICARE PROGRAM, PURSUANT TO SECTION 1875(b) OF THE SOCIAL SECURITY ACT

FOREWORD

Since the Medicare program went into effect on July 1, 1966, the Department of Health, Education, and Welfare has continuously studied the operation of the program with a view to assessing (1) its effectiveness with respect to the benefits provided and (2) its administration. Last year the Department submitted to the Congress the first annual report on the operation of the Medicare program, as required by section 1875(b) of the Social Security Act. The report presented herewith is in two parts: Part I represents the first report on studies and recommendations relating to the health care of the aged pursuant to section 1875(a) of the Social Security Act; part II represents the second annual report on the operation of the program pursuant to section 1875(b).

REPORT ON MEDICARE

Introduction: The Problem of Rising Medical Prices

The Health Insurance for the Aged Act (Medicare) enacted on July 30, 1965, has done much to alleviate the economic burden of health care for the aged segment of the population. Virtually all of the present aged are protected under the hospital insurance plan (Part A) of Medicare; those aged persons not protected are for the most part retired Federal workers, who have similar protection under a special system. And, despite the fact that protection is voluntary under the medical insurance plan (Part B) of Medicare, 95 percent of all the aged in the United States who could have enrolled for this protection have elected to do so.

It is perhaps because it directly affects so many people that the Medicare program has brought into sharp focus the fact that medical care prices have been increasing at an excessive rate for the past 3 years. The problems attached to these unprecedented rates of increase are not, of course, a matter of concern only to those involved with the Medicare program; they are now under scrutiny as a matter of concern to all Americans who use medical services and to all organizations (public and private) that provide insurance protection against the costs of medical care. However, the Medicare program, as the largest single purchaser of health care in the Nation—it pays for approximately one-third of all acute hospital care—has some potential for leverage that might help to slow down the rates of increase. To this end special efforts are being made to attack the problem through the Medicare program.

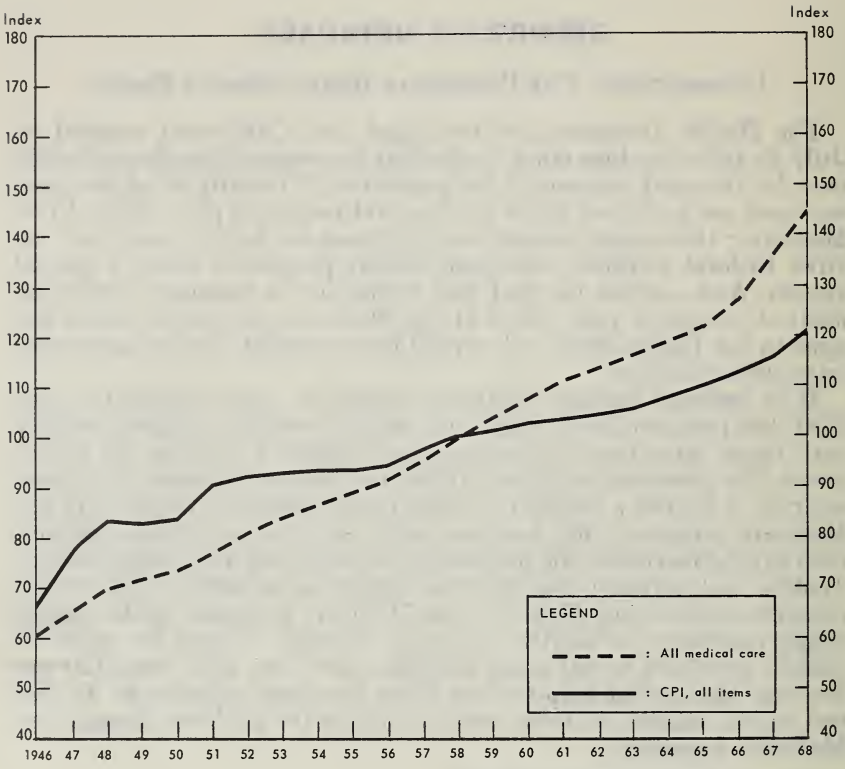
Origins of medical price increases

Since the end of World War II, medical prices have been increasing faster than consumer prices generally. In the 3-year period, 1966–68,[1] this trend became more pronounced when medical care prices increased sharply relative to all other consumer prices (see chart on p. 2). The largest increase occurred in hospital prices which rose a total of 47.8 percent in these 3 years. Physicians' fees increased 19.4 percent. In comparison, average hourly earnings for persons employed in manufacturing increased 14.4 percent and overall consumer prices increased 10.3 percent. (See chart on p. 3).

Different factors have contributed to the above-average rate of increase in hospital prices and physician fees. Hospital prices have been affected in a major way by the recent increases in salaries of hospital personnel. Wages of hospital employees had lagged significantly behind those in other sectors of the economy for many years. However, they have started catching up in recent years. In 1966 (the latest year for which wage data on hospital employees are available), 34.3 percent of hospital employees received wage increases of 10 percent or

[1] Data for 1968 include estimates for the most recent periods.

CONSUMER PRICE INDEX, U.S. CITY AVERAGE,
ALL ITEMS AND ALL MEDICAL CARE
1946 through 1968* (1957–59 = 100)

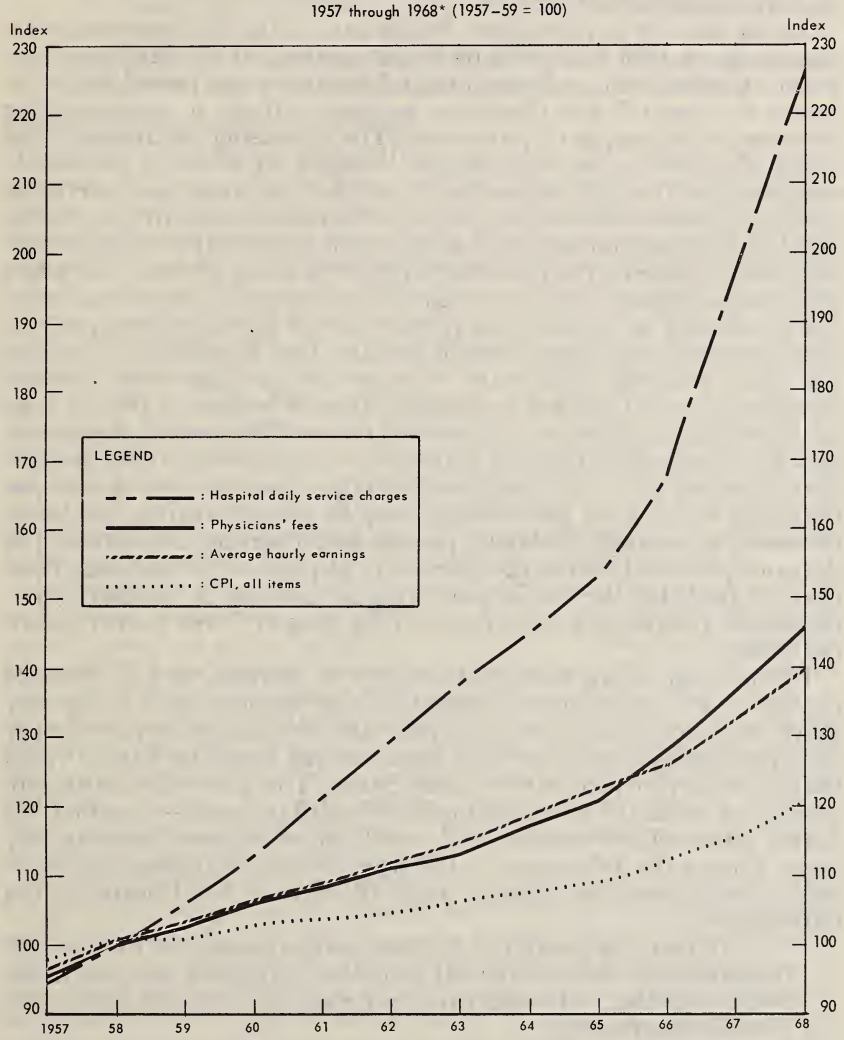


*1968 Estimated.

more as compared to wage increases of such magnitude for 0.5 percent of employees in manufacturing industries and 5.3 percent of employees in the service industries (excluding hospitals). Hospital employees receiving wage increases of 20 percent or more accounted for 7.6 percent of hospital employees, whereas no employees in manufacturing and only 0.7 percent of service-industry workers received such increases.

Among the factors contributing to the sharp increase in hospital wages were increased demands for wage increases by professional nurse organizations and unions, and shortages of skilled employees. Hospital managers have attempted to maintain equity between changes in the wages of union employees and the rest of the staff; thus, increases resulting from union negotiation have benefited all workers. Hospital managers may also have felt better able to accede to wage demands because of the prospect of some financial relief from financial burdens of older people through Medicare. The shortage of skilled labor in hospitals limiting the number of highly paid employees actually em-

CONSUMER PRICE INDEX, U.S. CITY AVERAGE,
ALL ITEMS, AVERAGE HOURLY EARNINGS IN MANUFACTURING,
AND SELECTED MEDICAL CARE SUBGROUPS,
1957 through 1968* (1957–59 = 100)



*1968 Estimated.

ployed, along with the substitutability of unskilled and semiskilled labor for skilled personnel, has tended to keep down the average rate of wage rise, although it has added to the growth in the number of hospital employees per patient and thus to hospital costs.

Another factor contributing to the increase in hospital wages is the fact that in February 1967, the Fair Labor Standards Act was amended to include hospital workers under its provisions. As a result of this legislation, 4.5 percent of all nonsupervisory hospital workers received a salary increase. Also, hospitals were required under the legislation

to pay premium wages for overtime; previously, hospitals with the largest majority of employees paid for overtime at straight-time rates or gave compensatory time off.

As for the rise in physicians' fees, a part of the fee increases occurring early in 1966 was perhaps in anticipation of the Medicare program. A more basic and continuing factor over the period is the increase in demand for physician services without a corresponding increase in the supply of physicians. The increasing awareness of the value of physician services and the lowering of financial barriers to such services through widespread insurance coverage have served to produce a greater demand for services. Medicare and medicaid, for example, have contributed significantly to the growth of the demand for services by lowering the financial barriers for many persons. The effect of increased demand and increased ability to pay for physicians' services is reflected in the fact that physicians' net earnings from practice have increased even faster than physicians' fees. According to the limited data available, physicians' average net earnings from practice increased about 11 percent in 1966 and about 8 percent in 1967 as compared with about 8 percent and about 6 percent increases in physicians' fees for comparable periods. Physicians' net earnings from practice also increased at a rate significantly higher than the rate of increase in hourly earnings of persons employed in manufacturing; the latter increased an average of about 3 percent and 5 percent, respectively, in the same years. Of course, the increase in physicians' net earnings from practice probably derives in part from an increase in productivity—physicians providing more services in the same or fewer hours of work per week.

The problem of an inadequate supply of services, such as those of physicians and nurses, which played such an important role in the very sharp increases in the costs of hospital and physicians' services is only one of the many problems which have evolved from the way in which health care is provided in the United States. The American health care system is a mosaic of public and private health programs—one that has grown piecemeal, without overall coordination, to meet needs as they arose. Among the deficiencies in the organization, financing, and delivery of health care that directly affect the costs of health care are the following:

1. In many communities the less costly alternatives to inpatient hospital care, such as hospital and other outpatient services, home health services, extended care facilities, and nursing homes are often in short supply.
2. In some communities, there is often an excess in supply—resulting in wasteful duplication of certain services and facilities, including some very expensive hospital services that involve heavy stand-by costs. Health facility planning is not now performed adequately.
3. Services, especially costly hospital services, are sometimes utilized unnecessarily; i.e., they are not medically necessary.
4. Many private health insurance plans produce undesirable incentives to use the most expensive methods of care.
5. Many possible hospital management improvements have not been adopted.
6. The growth of group practice has been retarded by legal bars and restrictive attitudes.

7. Productivity in the provision of medical care has not been defined and measured.

8. Insufficient attention is given to financing preventive care and health education.

9. There are insufficient financial incentives to restrain mounting hospital costs while maintaining high quality medical care.

Impact of rising medical care prices

Rapidly accelerating medical care prices do not affect any single segment of the population alone; rather, they affect every American who at some time may have to pay for medical services. While it is true that those Americans of moderate to low incomes, as well as those who require medical attention because of advanced age or severe disabilities, are more drastically affected by excessive increases in medical prices, such increases are not uniquely a problem of the poor, or the aged, or the chronically ill. Public attention has been focused on the marked and tangible, adverse impact of increased medical care prices upon the costs of the Medicare program and its beneficiaries, but the effect is in fact universal. The same effects are being experienced by other health insurers who are faced with the decision to either withhold additional protection or increase premiums to offset the increased costs. And, more dramatically, that segment of the population which is unable to purchase adequate health insurance must in many instances forgo needed medical attention because of its prohibitive cost.

Although the effect of the unprecedented rate of increase in medical care prices is universal, the effect is possibly best illustrated by the impact it has had upon the Medicare program. (Of course, many of the same effects have been felt in the medicaid program (title XIX) which is financed from Federal and State general revenues.) The most obvious effect that the rate at which medical care prices have increased has had on the Medicare program is that it has resulted in program costs that have been higher than expected. Since the separate parts of the Medicare program (part A, hospital insurance, and part B, medical insurance) are financed differently, the higher program costs pose a different set of problems for each part.

Benefit expenditures under the hospital insurance plan are estimated for a 25-year period into the future and allow for increasing hospital care costs, including higher increases in such costs during the early years than are assumed for the general earnings level. Experience to date indicates that the rate at which hospital care costs have increased exceeded the allowance provided for in the costs as estimated originally in 1965, but they have been in line with the revised assumptions contained in the estimates made in 1967. It is, of course, true that these increasing costs have been accompanied by higher than average increases in earnings and that the higher earnings have produced income to the program greater than expected, thus offsetting to some extent the impact of higher costs.

The supplementary medical insurance plan, on the other hand, is financed on a short-term basis. Benefit expenditures are estimated for only a 1-year future period (the current period is 15 months), and premium amounts to be paid by enrollees are set at a level that together with the matching contribution by the Federal Government is estimated to cover the cost of benefits and administrative expenses over

such period. Under the law, the Secretary of Health, Education, and Welfare is required in December of each year to determine and promulgate the standard premium rate that will apply during the 12-month period beginning July 1 of the succeeding year. The rate of increase in physicians' fees was one of several significant factors in the determination made during December 1967 to set the current premium at $4 per month, an increase of $1 over the initial rate. About 12 cents of the increase was accounted for by the fact that physicians' fees were higher during the first 1½ years than had been assumed in the estimate of the initial $3 rate. An additional 38 cents of the increase allowed for a 5-percent per year rate of increase in physicians' fees during the 15-month period, April 1, 1968–June 30, 1969, for which a $4 premium rate applied.

In connection with the determination of the medical insurance premium for the period July 1, 1969, through June 30, 1970, the social security actuary had estimated that physicians' fees would rise about 5 percent in 1969 and 4½ percent in 1970 (over 1969) and that medical services utilization under the program would increase about 2 percent in 1969 and 1½ percent in 1970. Under these assumptions, coupled with the assumption that the increases in fees and utilization would be fully reflected in the liabilities of the Medicare program, it would have been necessary to raise the premium to $4.40. However, the Secretary decided that it would be feasible to limit the program's liability sufficiently to keep within the current $4 premium. Several actions directed toward such containment are described in the following section of this report.

Dealing with medical care price increases

Considering the broad sweep of the problems which underlie the recent disproportionately rapid increase in medical care prices, it is clear that there are no simple, quick solutions. It is evident, however, that the Medicare program, which strongly feels the impact of price increases, is in a position to influence to some degree the factors that determine medical care prices. To this end a number of actions have been taken that should have beneficial effect. Briefly, the Social Security Administration has:

(1) Sponsored a series of nine regional conferences on health care costs as a follow-up to several major national conferences held by the Department of Health, Education, and Welfare in 1967.[2] The conferences were designed to bring together the leaders of the health community and the insurance industry, consumers and purchasers (both Government and private). Their aim was to approach the problem of rising health care costs at the State and local levels through the stimulation of experiments and innovations with incentives for cost effectiveness in the organization and delivery of health care services.

(2) As authorized under the Social Security Amendments of 1967, requested and sponsored proposals for experiments in Medicare reimbursement for health care which will have incentives for cost reductions. There are presently 4 approved experiments and several other proposals under consideration. (Details of this action are provided on pages 44 through 48 of part II of this report.)

(3) Changed the Medicare regulations regarding the confidentiality of records to permit release of information to local medical societies or

[2] National Conference on Medical Costs, National Conference on Private Health Insurance, National Conference on Group Practice.

State licensing bodies for review of professionally questionable physician activities. Also changed the confidentiality regulations to permit information, under certain conditions and subject to appropriate safeguards, to be disclosed to persons concerned with the interests of the beneficiary, who can thereby assist the program in the verification of overutilization or overcharging.

(4) Taken a number of actions to strengthen the administration and management of all aspects of the Medicare program at all levels, including the following:

(a) Issued additional guidelines to carriers (the private insurance organizations that pay medical insurance benefits) designed to obtain a greater degree of uniformity in the development of customary charges of individual physicians as well as the level of prevailing charges in various localities within each carrier's assigned geographical area. Reviews of carrier performance indicate there are wide variations among the carriers in the methods used to establish and revise customary and prevailing charge "screens." The new guidelines instruct carriers uniformly to use the "mean plus one standard deviation" method of determining prevailing charges—a method cited in the Medicare regulations as acceptable. This is expected to result in a maximum payment of approximately 83 percent of the fee range of all physicians for a given service as opposed to as much as 90 percent or more of the fee range for a given service adopted by some carriers. A further tightening of the "prevailing charge" concept is included among the legislative recommendations outlined in part I of this report.

The new guidelines are also designed to specify a uniform period of time in which an individual fee must be charged before it can be determined to be established as a customary fee, as well as specifying a minimum period between the time that a fee is established as a prevailing one in the locality and the time when an increase in that fee can be recognized.

Physicians have been urged to exercise unusual restraint in setting fees for the coming months and national medical, business, labor, and other leaders have been contacted and requested to cooperate. In addition, a meeting was held with the carriers to emphasize the importance of the role they are expected to play in helping to limit the liability of the Medicare program.

(b) Reminded State agencies in their resurveys of participating health care institutions to intensify surveillance of utilization review committee mechanisms to assure effectiveness of professional review of admissions and necessity of services as well as length of stay.

(c) Worked with carriers to incorporate into their claims processing mechanisms methods of identifying significant variations from the "norm," such as, for example, a method for promptly identifying individual physicians whose total billings for Medicare patients in given periods significantly exceed what would normally be expected in a practice of the type involved. Of course, physicians so identified will not necessarily have been guilty of improper practices. As indicated on page 64 of part II of this report, a special study was done this year with selected carriers; the investigation is continuing. The investigation of possibly question-

able situations may disclose some instances in which prosecution for fraud is in order and others in which the physicians' practices can be called to the attention of local medical societies under the new regulations, mentioned under (3) above, permitting disclosure of information for this purpose. Moreover, the investigations should help to serve as a deterrent to abuse.

The recommendations for legislative changes outlined in part I of this report include several proposals that would have a restraining effect on the rate at which medical care costs are increasing. Also, the Department has taken a number of other actions, going beyond the scope of Medicare, to improve the organization and delivery of health services and thus to secure greater efficiency and economy. For example, in response to a directive of the President, the Department has taken several major steps to achieve better coordination and more efficiency and economy in its operations. First, direct line authority over the Public Health Service and the Food and Drug Administration was vested in the Assistant Secretary for Health and Scientific Affairs. The Assistant Secretary's responsibility was also expanded to encompass overall health policy direction and coordination of other health and health-related programs, including Medicare, medicaid, and the health activities of the Children's Bureau.

A second major step was the reorganization of the Public Health Service, announced on April 1, 1968, including the creation of two new operating agencies, the National Institutes of Health, and the Health Services and Mental Health Administration. The Health Services and Mental Health Administration includes the primary programs in the Public Health Service relative to the organization and delivery of health services. These changes bring into a single agency all of the Department's programs directed to the organization and delivery of health services.

The Department has also established a National Center for Health Services Research which will lead the Federal effort to improve the quality and availability of health services and find ways to help curb rising costs. The Center will work with universities, industry, hospitals, practitioners, and research institutions to seek new ways to improve the delivery of health care. It will coordinate existing Department research programs and explore new methods of development, experimentation, and demonstration. The ultimate goal of the Center is to aid practitioners and institutions involved in health services to improve the distribution and quality of services and to make the best possible use of manpower, funds, and facilities.

The Department has also participated in several major efforts, involving the States and a large portion of the health care community, to deal with the problem of medical care costs on a broader front. Among the more significant of these efforts are, first, the regional medical programs which will make more readily available the best in modern medical science to people suffering from or threatened by heart disease, cancer, stroke, and related diseases. These regional medical programs—alliances between medical schools, hospitals, and local doctors—have been established in 55 regions covering the entire population. Recently, in keeping with the Department's efforts at controlling costs, the regional medical programs' guidelines have been revised to place greater emphasis on projects which ameliorate rising costs.

A second major effort is embodied in the Partnership for Health Act (Public Law 89–749). This act is intended to strengthen health care facility planning at all levels—local, State, regional, and Federal—and to encourage comprehensive, rather than categorical, public health services. The first task of the State planning agencies will be to clear away the financial, organizational, and jurisdictional barriers to the effective use of health resources. These efforts are now underway in many States. The legislative recommendation to coordinate Federal reimbursement to health care facilities with State health facility planning (see p. 15 of part I) could do much to strengthen State health planning.

A third effort is represented in the enactment of legislation designed to increase the output of health manpower. It is expected that this legislation will stimulate the establishment of 13 new medical schools and 8 new dental schools in the next 10 years, increase graduates of the allied health professions at the baccalaureate level, and provide incentives for existing schools to increase their output of medical, dental, nursing, and other students.

A fourth effort involves actions to promote the use of alternatives to inpatient hospital care. To this end the Department has: (1) contracted with the University of Vermont College of Medicine for the development and implementation of a plan that would involve undergraduate medical students in the use of all available health resources as part of the continuum of medical care in the community; (2) contracted with hospital organizations in Tennessee and Louisiana and with the Nebraska State Health Department for the purpose of stimulating collaborative working relationships between hospitals and all other health resources; and (3) participated in efforts to upgrade the effectiveness of State surveillance of patient-care programs.

The effort to control medical care costs is one of the most important challenges facing the Nation today. The Department's present policies call for a continued search for new ways of restraining rising medical care costs while improving the quality and increasing the availability of health care in the United States. These policies require that the Medicare program, and all other existing health-related programs within the Department's jurisdiction, be continuously reexamined.

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PART I. RECOMMENDATIONS FOR IMPROVING THE MEDICARE PROGRAM

(Pursuant to sec. 1875(a) of the Social Security Act)

Although the Medicare program has been in operation for only 2½ years, extensive consideration has been given to a wide spectrum of possible legislative changes which would improve the protection which the Medicare program provides. While several of these suggested legislative changes were considered as part of the several special studies relating to Medicare that were required under the Social Security Amendments of 1967, others have resulted from overall responsibility of the Secretary of Health, Education, and Welfare for continually studying ways in which all parts of the social security program can be improved. Recommendations with respect to legislative changes in Medicare benefits, as well as in the financing or administration of the program, are discussed below. The first section deals with major changes that would involve substantial costs or that would require fundamental changes in the present structure of the Medicare program. The second section discusses additional areas in which relatively minor changes are proposed and some areas for further study.

A. MAJOR RECOMMENDATIONS

1. Extend Medicare protection to disabled social security beneficiaries

Under the present Medicare law, only aged social security beneficiaries are entitled to Medicare benefits. However, it has been generally recognized that those social security beneficiaries who are getting monthly cash benefits because they are severely disabled have a need for Medicare protection. The severely disabled, like the aged, have greatly reduced incomes and high health costs, and have difficulty obtaining adequate private health insurance.

In 1967, the 90th Congress deferred action on the Johnson administration's recommendation that Medicare protection be extended to disabled social security beneficiaries, largely because information that became available during the course of congressional consideration showed that the cost of providing this coverage would be higher than anticipated; the Social Security Amendments of 1967 provided for an advisory council to study the unmet need of the disabled for coverage under Medicare and the methods of financing such protection for these individuals, and to report its findings and recommendations to the Congress. The report of this council has recently been transmitted to the Congress.

The council found that the severely disabled have a need for health insurance protection under Medicare and recommended that this protection be provided for the disabled on the following basis:

(*a*) The existing hospital and medical insurance programs under title XVIII of the Social Security Act (Medicare) should

be extended to those receiving social security monthly benefits on the basis of their disabilities.

(*b*) Hospital and medical insurance benefits for the present disabled, as well as for those who become disabled in the future, should be financed by contributions from employees, employers, and the self-employed, with a contribution from Federal general revenues equal to one-half the cost of the program.

(*c*) Instead of the 6-month waiting period required in present law for receipt of social security disability benefits, a 3-month waiting period should be required for hospital and medical insurance benefits. The requirement in the cash benefit program that a disability must have lasted or be expected to last at least 12 months or to end in death should not apply in the case of Medicare benefits.

(*d*) Older disabled workers should qualify for Medicare protection on the basis of less severe disability than is required under present law for eligibility for cash benefits. Insured workers aged 55 and over should be eligible for Medicare if they are so disabled that they can no longer engage in substantial gainful activity in their regular work or in any other work in which they have engaged with some regularity in the recent past.

The Secretary has recommended that Medicare be extended to all disability cash beneficiaries under social security.—This would include disabled workers, adults disabled since childhood, and disabled widows and widowers, and would provide Medicare protection for 1.7 milion persons receiving cash social security disability benefits on the basis of the present disability insurance program. The Secretary has also recommended that eligibility for disability cash benefits under social security be provided, for some 0.3 million people who would meet a 3-month waiting period, without any prognosis requirement; therefore, if these recommendations are enacted, both Medicare and cash benefits would be payable on the basis of a 3-month waiting period and without any prognosis requirement.

While there is a problem with respect to those older workers who are unable to carry on their regular work because of disabilities, first priority should be given to providing health insurance protection for the severely disabled, and no recommendation with respect to the occupationally disabled is being made at this time.

Also, there are significant gaps in the health care protection of people under age 65 who are not social security disability beneficiaries—people who have little or no income, people who have no regular connection with the work force and have serious problems in obtaining private health insurance that is adequate and that they can afford, and people who have disabling conditions that make it difficult, or even impossible, for them to obtain work income. By providing coverage for the worst health risks—those age 65 and over—the Medicare program has offered private health insurance the opportunity to make broadened protection available to those persons under age 65. Private health insurance itself recognizes that it has an opportunity and a responsibility to reach all those not covered under public programs and who are still uninsured or underinsured against the costs of health care and provide them with adequate protection at a reasonable cost.

The extent to which private insurance meets this responsibility will determine whether the Federal Government will need to play a larger role in providing such protection.

The Secretary has also recommended health insurance protection be extended to the disabled on a contributory social insurance basis.—This method of financing would be in keeping with the recommendation that the financing and eligibility provisions of the medical insurance program be combined with those of the hospital insurance program (recommendation 3, below). Equally important, this method of financing Medicare for the disabled would resolve the serious questions of financing and equity that arose, during congressional consideration of social security legislation in 1967, in connection with financing medical insurance for the disabled under the provisions of present law.

Since the medical insurance costs of the disabled are substantially greater than are those of the aged, the medical insurance premium would have had to have been very high if the disabled were to pay half the cost of their own protection as do the aged under the existing program. The alternative of requiring the aged to pay part of the higher cost of insuring the disabled was not considered an equitable one. The social insurance financing approach provides a reasonable, equitable, and acceptable method of distributing this cost.

2. Cover certain maintenance drugs under Medicare

The Social Security Amendments of 1967 required the Secretary of Health, Education, and Welfare to study the possible coverage of drugs under the voluntary medical insurance part of the Medicare program. The Department's report on this question has recently been transmitted to the Congress. In summary, the Department has found that the elderly have a need for improved protection against the high cost of prescription drugs and that providing a drug benefit under Medicare would be an appropriate method of relieving the aged of part of the burden of high drug costs. It has also found that because of the numerous and complex problems involved in providing a drug benefit, which involves a claims volume many times that of the present Medicare program, it would not be desirable, at least in the first years in which the new benefit would be available, to try to provide total protection against the prescription drug costs incurred by the elderly. Finally, it was found that while it would be feasible to provide a drug benefit under either the hospital insurance or supplementary medical insurance parts of the Medicare program, there are significant advantages, in terms of program financing and beneficiary eligibility, in providing this coverage under the hospital insurance program.

The Secretary has recommended that coverage of part of the costs of prescription drugs incurred by the aged be covered under part A of the Medicare program. Specifically, Medicare coverage should be extended to those drugs that are important for the treatment of diabetes and those chronic cardiovascular, respiratory, and kidney diseases that commonly afflict the aged.—This approach to drug coverage under Medicare would have the advantage of keeping within manageable limits the administrative problems that would be associated with the new benefit, and would concentrate the protection where it is needed most.

3. Finance both hospital insurance and supplementary medical insurance through the contributory social insurance mechanism

Under present law, the two parts of the Medicare program are financed differently and have different eligibility requirements. The hospital insurance part of the program is financed through payroll contributions; virtually all of the present aged are entitled to hospital insurance benefits. Entitlement to hospital insurance is based on entitlement to monthly cash benefits under social security or the railroad retirement program. The supplementary medical insurance program, in contrast, is financed through monthly premiums paid by those persons electing to enroll in the program, and by matching amounts paid out of the general revenues.

About 95 percent of the aged are enrolled in the medical insurance program at the present time; it is clear, therefore, that the aged believe that they need the protection the program offers. However, despite the widespread acceptance of the program by the aged, it has become apparent that the medical insurance plan has several disadvantages, as compared to the hospital insurance program, in terms of beneficiary eligibility and the financing of benefits. It is recommended, therefore, that the financing and entitlement provisions of the medical insurance part of the Medicare program be combined with those of the hospital insurance program, so that the entire program would be financed primarily through the payroll contribution mechanism, and so that individuals insured under social security and their dependents would automatically become entitled to medical insurance benefits when they become age 65 and qualify for social security benefits. As is the case with the present medical insurance plan, part of the cost of the combined program should be met through general revenues contributions. The recommended change would involve only the areas of financing and eligibility; the distinctions between the types of benefits and the methods of administration and reimbursement under the two plans would be retained, including the use of carriers and intermediaries.

The major advantage of combining the financing and eligibility provisions of the medical insurance and hospital insurance parts of Medicare would be that beneficiaries would be relieved of having to pay monthly premiums on a current basis, at a time when they are likely to have extremely limited income and assets. While the current monthly premium rate of $4 which each medical insurance beneficiary must pay is a relatively modest amount, considering the scope of the benefits provided, there is every reason to believe that many beneficiaries find it difficult to meet this amount. About 5.8 million of the aged social security beneficiaries have incomes below the poverty line and about 3 million more are in the near-poor group. And about 15 million aged have incomes so low they do not pay an income tax. Individuals with such limited incomes would benefit substantially if the medical insurance program were financed during their working lifetimes rather than when they have reached retirement age.

Financing medical insurance protection through the payroll contribution mechanism has additional advantages in light of the probability that medical care prices will continue to increase. Under the present financing of the medical insurance program, increases in health costs or substantial increases in utilization must be paid for, through in-

creases in the monthly premiums, on a year-to-year basis as the cost increases occur. If the medical insurance plan were financed through payroll contributions, increases in health costs and the utilization of covered services could be taken into account in establishing the contribution rates and thus averaged and paid for over a substantial period of time. Also, with contributions based on earnings, increases in the general earnings levels that can be expected to occur in the future would automatically provide additional income to the system to help meet increases in health costs.

Another advantage of combining the financing and eligibility provisions of the hospital and medical insurance parts of Medicare is that administration of the program would be greatly simplified. At present, the process of enrolling eligible beneficiaries in the medical insurance program, and collecting the monthly premiums, involves substantial workloads. Additional workloads result from the fact that the various restrictions on enrollment, disenrollment, and reenrollment that are necessary in order to guard against a high degree of adverse selection in a voluntary insurance program result in considerable confusion on the part of beneficiaries. Further complications result from the coordination of the Medicare program with the Federal-State assistance program, in cases where the assistance program purchases medical insurance; this coordination generates significant workloads for the assistance programs, which must keep track of premiums and the eligibility of their beneficiaries.

The Secretary has recommended that both the hospital and the medical insurance parts of Medicare should be financed on the basis of payroll contributions, with a matching contribution from general revenues, and that entitlement to medical insurance, like entitlement to hospital insurance, should be based on entitlement to social security cash benefits.

4. Coordinate Federal reimbursement to health care facilities with State health facility planning

As mentioned earlier in this report, duplication of facilities and excess equipment are considered to be responsible for part of the high cost of hospital care. In an effort to alleviate problems deriving from such duplication and excess equipment, Federal legislation (Public Law 89–749—the Partnership for Health Act) was enacted by the Congress, providing additional support for planning in the States through grants to the States for comprehensive health planning and through project grants to other public and nonprofit private agencies. In addition, the National Blue Cross Association has recently urged its 75 health plan agencies to adopt a program that would, among other things, withhold reimbursement from hospitals that refused to cooperate with regional health planning agencies. Also, both the American Hospital Association and the American Medical Association have advocated better health planning.

Under the present provisions of title XVIII, depreciation on buildings and equipment is an allowable cost under the principles of reimbursement for provider costs. Funding of depreciation is not required although an incentive for funding is provided by not treating investment income on funded depreciation as a reduction on allowable interest expense. If funding were required, it would provide some assurance

of the availability of funds for future expansions and acquisitions of equipment. Also, there is no specific restriction on payment of depreciation related to whether the depreciable items were constructed or purchased in conformance to any type of planning requirements. Similarly, there are no specific restrictions under titles V and XIX of the Social Security Act with respect to funding depreciation or conforming to planning requirements. Therefore, although Federal legislation has resulted in substantial expansion in State planning activity, and further expansion can be expected, Federal health programs as presently constituted could undercut State health planning measures.

It is recommended that titles XVIII, XIX, and V of the Social Security Act be amended to provide that if a medical facility fails to secure approval of a State health planning agency for a substantial capital expenditure, the Secretary would be authorized to withhold depreciation amounts attributable to such substantial capital expenditure an d payable under titles XVIII, XIX, or V. It is further recommended that the Secretary be authorized to withhold depreciation payments if a medical facility fails to set aside payments for depreciation made under such programs in separate funds to be used for capital purposes.

Not only would such legislation help to reduce health costs caused by the duplication of facilities and equipment, it would, by encouraging planning activities, assist in providing a comprehensive system of health care delivery by fostering the establishment and expansion of economic alternatives to hospital care.

B. OTHER RECOMMENDATIONS AND STUDIES

At the same time that we must work to strengthen the basic structure of the Medicare program and fill the most significant gaps in the protection the program provides, we must also look to other less far-reaching means of improving the benefits provided and the overall operation of the program. The following proposals would make such improvements either without involving any substantial increase in program costs or with an actual saving to the program.

Implementation of incentive reimbursement mechanisms.—Under the Social Security Amendments of 1967, the Secretary is authorized to experiment with various methods of reimbursement to institutions and payment to physicians providing services covered under Medicare, medicaid, and the maternal and child health programs with a view to creation of additional incentives to efficiency and economy while supporting high quality services. (See p. 44 of part II of this report.) The experimentation provisions, authorized under these Federal health programs, would be strengthened by permitting prompt application of effective incentive reimbursement mechanisms on a regular basis in such cases, in such geographical areas, and for such services as may be appropriate. Presently, any incentive procedure proved effective requires additional legislation prior to implementation. Conceivably, significant savings could be lost pending congressional action. An administration bill, H.R. 16616, introduced in 1968, included a provision that would authorize the Secretary to employ new methods of payment based upon those experiments authorized by the 1967 social security amendments. However, no action was taken by the Congress. Enactment of such legislation is again recommended.

Preventive care.—It is generally recognized throughout the health care field that certain types of preventive care services such as periodic physical examinations have significant value in promoting good health among the aged. As originally enacted, the Medicare program was designed to deal primarily with the problem of meeting the high health costs associated with acute illness and did not cover preventive care services generally. The Department has recently completed a careful review of these provisions and the possible coverage of preventive care services under Medicare, as requested by the Senate Finance Committee in its report on the 1967 social security amendments. It was found that a broad proposal for covering preventive care would be unrealistic in terms of present availability of such services. The Secretary has recommended, however, that the legislative intent of the present Medicare law be clarified to specify that when an aged patient presents himself with a complaint to his physician, the physician will have the assurance that any tests or examinations that are necessary will qualify as "covered services" for which reimbursement can be made under Medicare. The Secretary has also recommended that Federal funds be appropriated to support a national, cooperative, voluntary educational effort to encourage better health practices among the aged and to stimulate their utilization of preventive services.

Additional health practitioners.— Since the program began there has been interest in covering the services of independent health practitioners who are not physicians. Generally, these types of services are now covered by Medicare only when they are part of the services provided by hospitals, extended care facilities, and home health agencies, or when provided as an incidental part of physicians' services. The Department recently completed its study, requested by the Congress under the 1967 social security amendments, of the feasibility of covering under the medical insurance part of the Medicare program additional types of services such practitioners perform. The study findings demonstrate the need of making Medicare coverage of certain types of practitioner services more readily available on an outpatient basis. The services of many nonphysician health practitioners are now covered when provided to inpatients, but when they are discharged the beneficiaries find that coverage of the services to outpatients is limited. The Secretary has recommended that coverage be extended, under certain limited conditions, to include services of occupational therapists, clinical psychologists, social workers and speech pathologists that are not now covered under the Medicare program. The recommended method of coverage of the services—that is, by covering specified services where provided by or through institutional providers of services, rather than covering the services of self-employed nonphysician practitioners as such—would help to extend the availability of these services to beneficiaries on an outpatient basis, without involving a serious risk of loss of control over the quality and coordination of these services and without unduly increasing program costs. The proposed method of coverage was patterned after the provision in the Social Security Amendments of 1967 which covered additional outpatient physical therapy services.

Determination of reasonable charges for services.—Present Medicare law provides that payment for medical and other health services furnished by physicians or other persons is to be made on the basis of

"reasonable charges." In determining "reasonable charges" carriers (health insurance organizations selected to make payments under the medical insurance plan) must take into consideration the customary charges for similar services generally made by the physician or other person furnishing such services and the prevailing charges in the locality for similar services. Also, carriers are to assure that such charges are not higher than the charges applicable for comparable services under comparable circumstances to their own policyholders and subscribers. Guidelines for establishing customary and prevailing charge levels are provided to carriers in the form of regulations.

A major consideration in not using the fixed-fee approach in Medicare was that in past experiences under welfare programs whenever fee schedules were used the limits were set at too restrictive a level so that often the better qualified physicians refused to participate in the program, and thus their services were not available to many welfare recipients. Basing the medical insurance payment on reasonable charges, therefore, would appear to provide the best assurance of participation of virtually all physicians.

As mentioned previously, additional guidelines designed to obtain a greater degree of uniformity in the development of customary charges of individual physicians as well as the level of prevailing charges were recently issued to carriers. The new guidelines instruct carriers to use the "mean plus one standard deviation" method of determining prevailing charges. The use of this method is expected to result in a maximum payment of approximately 83 percent of the fee range of all physicians for a given service as opposed to as much as 90 percent or more of the fee range for a given service adopted by some carriers. The new guidelines are also designed to specify a uniform period of time in which an individual fee must be charged before it can be determined to be established as a customary fee, as well as specifying a minimum period between the time that a fee is established as a prevailing one in the locality and the time when an increase in that fee can be recognized. Thus the implementation of these guidelines is also expected to result in a slowdown in the rate at which carriers introduce fee increases into their customary charge schedules.

Since the guidelines relating to the establishment of prevailing charges now appear to be of greater significance than was the case at the program's inception and since there is an obvious need to exercise control over program expenditures, it would seem that guidance with respect to prevailing charges should be provided in the law. It is recommended, therefore, that the Medicare law be amended to specify that the prevailing charge is to be established at a level that will include 75 percent of the fee range in a locality for a given service.

Such legislation would provide greater uniformity in the determination of reasonable charges and would also help to control the rising costs of medical care. It would not raise the problems associated with fixed fees nor endanger the availability or quality of services available to Medicare beneficiaries.

Areas for further study

The Department is continually engaged in studies of the overall adequacy of the social security program, including Medicare. In addition, all aspects of the Medicare program are reviewed by two statutory

advisory councils. The Advisory Council on Social Security, which will be appointed in 1969, is required to study all aspects of the social security program including the financing and the adequacy of benefits under Part A and Part B of Medicare. The Health Insurance Benefits Advisory Council, which is an ongoing group, is authorized to advise the Secretary on all matters of general policy relating to Medicare and to recommend needed changes in the program. This Council is required to report to the Congress annually, and its report is expected to be released early in the spring of 1969.

It is likely that the cost-sharing provisions of the program will receive extensive consideration. (Under the present Medicare law, both the hospital insurance and medical insurance plans include deductible and coinsurance amounts for which the beneficiary is responsible, the most important of which are a variable deductible—$44 beginning January 1969—with respect to inpatient hospital services, a $50 annual deductible with respect to medical insurance services, and a 20-percent coinsurance amount under the medical insurance plan.) These various provisions have been the subject of periodic criticism from beneficiaries, physicians, intermediaries and carriers helping to administer the program, and providers of services, although such criticism has diminished somewhat in intensity as those concerned have gained a better understanding of how the provisions operate. While it is recognized that the cost-sharing provisions do cause recordkeeping problems for beneficiaries and providers of services, as well as other administrative difficulties, and can result in a financial hardship for some beneficiaries, it is also recognized that under existing conditions such provisions play an important role in keeping program expenditures within acceptable limits. As additional experience develops, the cost-sharing provisions will be carefully reviewed.

Another program area in which there has been considerable interest relates to the coverage of patients with mental illness under the Medicare and medicaid programs. The Senate Finance Committee in its report on the 1967 Social Security Amendments asked that there be a study of the experience with these benefits under the provisions of the 1965 admendments, and an evaluation of the problems involved in expanding or extending those provisions. The Department has completed an interim report which discusses the results of the study thus far, and points up the need for further analysis before submitting final recommendations.

PART II. SECOND ANNUAL REPORT ON THE OPERATION OF THE MEDICARE PROGRAM

(Pursuant to Sec. 1875(b) of the Social Security Act)

Table of Contents

COMPARATIVE HIGHLIGHTS

	Fiscal 1968	Fiscal 1967
Number of beneficiaries (as of June 30):		
Hospital insurance (Part A)	19, 697, 000	19, 358, 000
Medical insurance (Part B)	18, 798, 000	17, 869, 000
Providers of services (as of June 30):		
Hospitals	6, 865	6, 857
Extended care facilities	4, 702	4, 160
Home health agencies	2, 093	1, 849
Independent laboratories	2, 566	2, 136
Benefits paid:		
Hospital insurance (Part A)	$3, 736, 000, 000	$2, 508, 000, 000
Medical insurance (Part B)	$1, 390, 000, 000	$664, 000, 000
Use of benefits:		
Inpatient hospital admissions	5, 655, 000	4, 967, 000
Extended care facility admissions (fiscal year 1967, 6 months)	448, 000	199, 000
Home health plans started	258, 000	228, 000
Bills paid, outpatient hospital services	3, 010, 600	1, 414, 000
Bills paid, physicians' and other medical services	30, 809, 000	13, 681, 000
Administrative expenses:		
Hospital insurance (Part A)	$79, 000, 000	$89, 000, 000
Medical insurance (Part B)	$143, 000, 000	$134, 000, 000

Introduction

This annual report documents the performance of Medicare in its second year—from July 1, 1967, through June 30, 1968. It is a substantial performance in terms of total benefits paid, the achievement of almost universal coverage of those 65 and over, the reduction of both claims processing time and the unit cost per claim processed, the establishment of more effective review mechanisms to monitor the quality of care furnished by providers and to identify improper or excessive utilization of services, and in terms of the many other administrative refinements and operating improvements which are described in this report.

It is, of course, more than a record of performance by the Federal Government, by intermediaries and carriers, and by State agencies, each seeking to carry out the full measure of its administrative responsibilities. It is, more importantly, a record of cooperative venture—and cooperative achievement—between the Medicare program and the vast health care system of this Nation. The accomplishments of medicare are also, in large measure, the accomplishments of the health community. That Medicare, in its second year, has paid over $5 billion in benefits is another way of saying that the health community has furnished well over $5 billion in services to the elderly. That Medicare is processing tens of millions of claims with increasing speed and accuracy is also to say that thousands of health facilities and hundreds of thousands of physicians and suppliers are more promptly and accurately furnishing the patient care information required by the program. To give credit to the improvements in Medicare's policies and procedures is also a measure of the debt that Medicare owes to the health community for its continuing counsel and cooperation.

But, there is another dimension of Medicare which no record of administrative performance can adequately convey—a dimension which, in fact, a record of administrative performance can sometimes obscure. That dimension lies in the realm of mind and heart, which is itself unmeasurable, and, yet, is the only true measure of everything else. There is a part of every annual report on Medicare that should be written by the nearly 20 million elderly whom Medicare exists to serve. These millions of voices would add perspective to a report which, in its emphasis on Medicare's operations, may give inadequate attention to Medicare's effects.

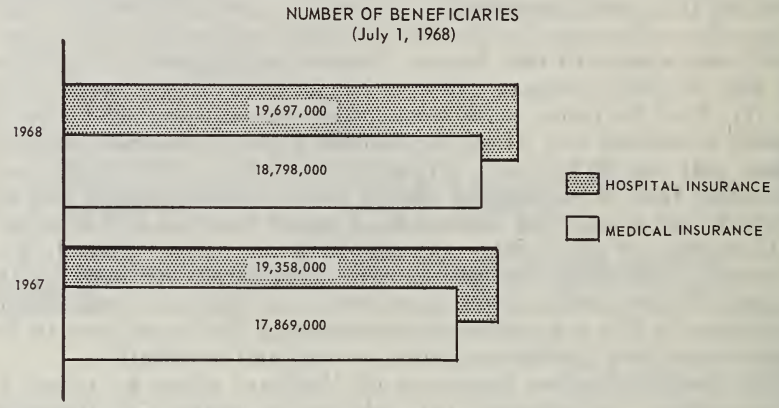
That important part of the annual report would record that Medicare has restored more dignity to the elderly than the rest of this Nation ever knew they had lost—that it has erased more fear among them than the rest of this Nation ever suspected they had felt—that it has brought more health services within their reach than the rest of this Nation ever recognized they were doing without. That more eloquent part of the annual report would remind any who might otherwise forget, that the purpose of Medicare is people, and that the pride of Medicare is in what it adds to the quality of their lives.

How well Medicare continues to serve that purpose—and deserve that pride—will always be the truest test of its administrative performance.

Chapter I. Program Operations

BENEFICIARIES

By July 1, 1968, 19.7 million persons [1] were entitled to hospital insurance—nearly all of the Nation's population age 65 and over. The number of persons entitled to hospital insurance at the end of Medicare's second fiscal year was over 300,000 higher than the total in July 1967, reflecting the growing number of persons over 65 in the total population.



There were 18.8 million persons enrolled in the voluntary medical insurance program on July 1, 1968—representing over 95 percent of the aged population entitled to hospital insurance. This is a substantial increase over the 17.9 million persons enrolled for medical insurance at the end of the preceding fiscal year. A major part of the net gain was accounted for by the approximately 700,000 persons who were added to the medical insurance rolls in the first open enrollment period from October 1, 1967 through March 31, 1968.[2]

HEALTH CARE RESOURCES

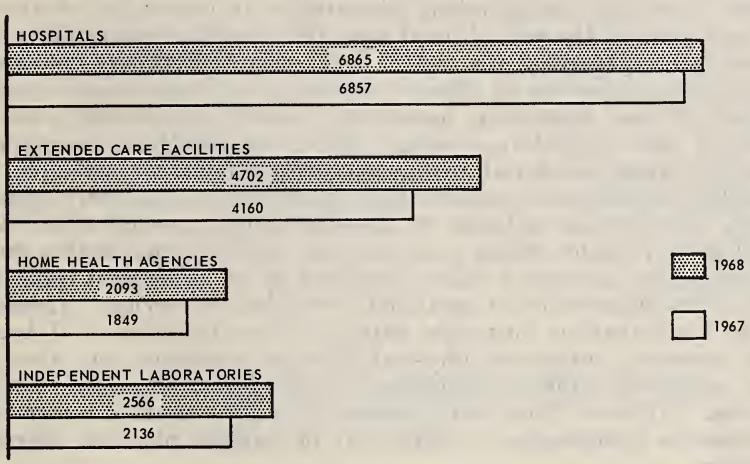
In fiscal year 1968, there were significant increases in the number of health care resources participating in the program or approved for Medicare reimbursement. New categories of health care resources were

[1] Excluded from coverage are certain Federal employees covered under the Federal Employees Health Benefits Act, aliens admitted for permanent residence but not residing in the United States for 5 consecutive years preceding their application for hospital insurance entitlement and persons convicted of crimes against the United States. Included in the total are 146,000 beneficiaries residing in foreign countries and 159,000 persons living in Puerto Rico and United States territories and possessions.

[2] Under the original law, general enrollment periods for the voluntary medical insurance program were to occur in the last 3 months of every odd-numbered year. Public Law 90–97 extended the first general enrollment period through March 31, 1968. Subsequently, the 1967 amendments provided for an annual general enrollment period from January 1 to March 31.

added by the 1967 amendments,[3] but more importantly, a number of previously nonparticipating providers came into the program as a result of upgrading their health care capability to meet the program's conditions of participation or by coming into compliance with civil rights requirements.

NUMBER OF PARTICIPATING PROVIDERS AND APPROVED INDEPENDENT LABORATORIES
July, 1967 and July, 1968



At the end of fiscal year 1968, there were 6,865 hospitals participating in Medicare, with 1,165,000 beds—all but about 2 percent of the acute care, adult hospital beds in the country. Included among the participating hospitals were 6,406 general and specialty hospitals, 341 psychiatric hospitals, and 118 tuberculosis hospitals. Seventy percent of the 1,165,000 certified beds are located in general hospitals; psychiatric hospitals account for 28 percent of the beds, and tuberculosis hospitals the remaining 2 percent.

As of June 30, 1968, there were 4,702 extended care facilities with 330,000 beds participating in Medicare—over 50 percent of the Nation's skilled nursing beds in nonhospital facilities. The major factors contributing to the net increase of 542 facilities over the 1967 totals are the number of new extended care facilities being built and the number of older skilled nursing homes being upgraded to meet the program's health care standards. Participating facilities include not only skilled nursing homes, but also separately organized extended care units in hospitals as well as some separate skilled nursing units connected with residential homes for the aged.

At the end of the fiscal year, a total of 2,093 home health agencies were certified to participate in Medicare—a gain of 244 from the number participating at the end of fiscal 1967. Over one-third of the participating agencies offer the basic requirement of visiting nurse care and one additional health service. Nearly two-thirds provided two

[3] See Appendix A for a summary of the 1967 Amendments.

or more additional services in addition to visiting nurse care. Approximately two-thirds of the agencies provide physical therapy services; over two-fifths offer home health aide services; about one-fifth provide medical supplies and equipment; and over one-third provide occupational or speech therapy. Participating home health agencies are predominantly official health agencies and visiting nurse associations. About 10 percent are hospital or extended care and other facility-based programs.

There were 2,566 independent laboratories approved for Medicare reimbursement at the end of fiscal year 1968—an increase of 430 over the number approved at the end of fiscal year 1967. There are seven reimbursable categories of clinical tests or procedures: microbiology, serology, clinical chemistry, hematology, immunohematology, tissue pathology and exfoliative cytology. About one-fourth of the laboratories were approved for all seven types of procedures.

The 1967 amendments provide that, beginning July 1, 1968, physical therapy services—in addition to those presently covered when furnished in physicians' offices or as part of covered home health services—may also be covered when furnished on an outpatient basis by, or under the supervision of, qualified "providers of services". In addition to participating hospitals, extended care facilities, and home health agencies, outpatient physical therapy providers may also include approved clinics, rehabilitation agencies and public health agencies. Fifty-five clinics and agencies have been certified under this provision to participate as additional outpatient physical therapy providers.

Effective January 1, 1968, as a result of the 1967 amendments, medical insurance benefits became payable, under certain conditions, for diagnostic X-ray services provided in a beneficiary's home by nonphysician portable X-ray operators. To be reimbursable, the operator's services must be performed under the general supervision of a physician and must meet strict health and safety requirements. Approximately 140 suppliers of portable X-ray services have been certified as meeting these conditions.

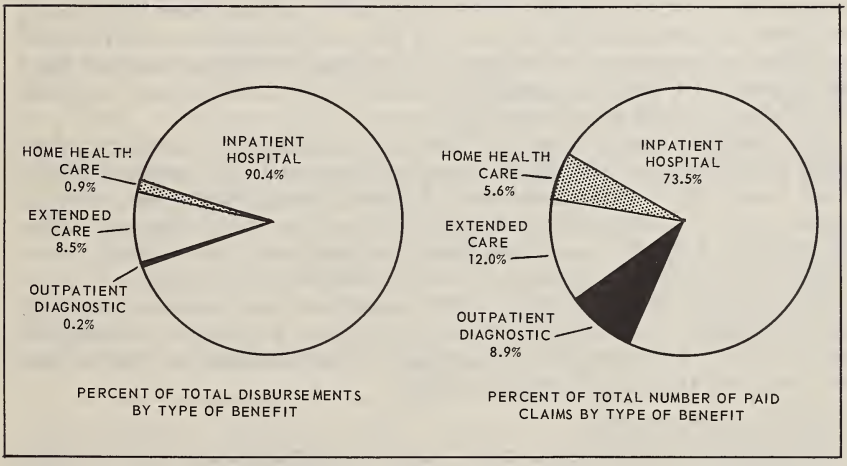
Suppliers of ambulance services, as a condition of payment under medical insurance, are required to file a statement certifying that their vehicles are specially designed and equipped for transporting the sick or injured, and that their patient care equipment and personnel meet all the first aid and safety requirements specified under the Medicare program. In addition to ambulance services under the supervision of participating providers, many independent suppliers of ambulance services have met the conditions necessary for payment.

The purchase or rental of medically necessary durable medical equipment is covered under medical insurance when prescribed by a physician for use in the beneficiary's place of residence. This equipment constitutes such items as oxygen tents, hospital beds, wheelchairs, crutches and walkers. Durable medical equipment suppliers include outlets which specialize in renting or selling such equipment, as well as an indeterminate number of drugstores and similar nonspecialized suppliers.

BENEFIT PAYMENTS [4]

During the second year of Medicare, the program paid $3.736 billion in benefits under hospital insurance and $1.390 billion under medical insurance. Both amounts were up substantially from the first-year figures of $2.508 billion and $664 million, respectively. It must be noted, however, that these substantial increases in disbursements in the second year of Medicare do not represent an equivalent increase in program costs for 1968 as compared to 1967. A significant portion of fiscal 1968 disbursement was attributable to services actually rendered in fiscal 1967, for which the claim was not processed and paid until fiscal 1968, either due to processing lags or delays by providers and beneficiaries in submitting claims. This was particularly true for medical insurance disbursements; at the beginning of fiscal 1968 there was an unprocessed workload of almost 1,500,000 medical insurance claims. In addition, unusually high workloads were encountered toward the end of calendar 1967, and in early 1968, indicative of a tendency by beneficiaries to accumulate medical bills for the entire calendar year and to submit them at the end of the year or shortly thereafter.

PERCENTAGES, BY TYPE OF BENEFIT, OF TOTAL DISBURSEMENTS AND TOTAL NUMBER OF PAID CLAIMS UNDER HOSPITAL INSURANCE – FISCAL YEAR 1968



Of the total number of hospital insurance claims approved for payment in fiscal 1968 and recorded in SSA records, 73.5 percent were for inpatient hospital services, 12 percent were for extended care services, 5.6 percent for posthospital home health services, and 8.9 per-

[4] Except for the disbursement amounts in the first paragraph, which are based on Treasury Department advances to intermediaries and carriers for benefit payments and except where otherwise noted, all statistics in this section are based on claims received and processed into Social Security Administration records as of November 8, 1968. Because of lags in submitting bills and recording data, the latter amounts do not always add up to Treasury Department totals.

cent for outpatient diagnostic services (effective April 1, 1968, all outpatient hospital services—diagnostic and therapeutic—were consolidated under medical insurance). Inpatient hospital services, however, ıccounted for 90.4 percent of total fiscal 1968 hospital insurance benefit payments, while 8.5 percent was attributable to extended care serv.ces, 0.9 percent for posthospital home health services, and 0.2 percent for outpatient hospital diagnostic services.

Of the total number of medical insurance bills approved for payment in fiscal 1968 and recorded in Social Security Administration records, 81.3 percent were for physicians' services, 11.8 percent for outpatient hospital services, and 6 percent were for home health services (not requiring prior hospitalization), independent laboratory and other medical services. Physicians' services accounted for 91.7 percent of total fiscal year medical insurance benefit payments, while 2.5 percent was attributable to outpatient hospital services, and 4.7 percent to home health, independent laboratory, and other medical services.[5] Of claims submitted for physicians' services in fiscal 1968 (other than hospital-based physicians), 56 percent were assigned.[6]

Inpatient hospital services

There were nearly 5.7 million covered hospital admissions under Medicare in its second fiscal year, an increase of almost 700,000 admissions over the first year. This amounted to an annual average of 291 admissions to short- and long-term hospitals for every 1,000 persons covered under the program, an increase of 11 percent over the preceding year. An estimated 20 percent of the total admissions represented second or subsequent admissions. The average number of covered days of hospital care per recorded claim was 13 days in short-stay hospitals and 35 days in long-stay hospitals.

For the year ended June 30, 1968, 25,400 claims for emergency hospital services were processed—less than one-half of 1 percent of the total claims for hospital services.[7] Approximately 83 percent were allowed and 17 percent were either fully or partially denied. About 90 percent of these claims were from the South and Southwest, where there are the greatest number of nonparticipating hospitals.

For the year ended June 30, 1968, hospitals were paid an estimated $3.3 billion for inpatient hospital services, an increase of about $900 million over the preceding 12 months. Reimbursement averaged $558 per recorded inpatient hospital claim.

Extended care services

Admissions to extended care facilities during fiscal 1968 totaled almost 450,000, an annual rate of 23 per 1,000 persons covered. This compares with about 200,000 admissions in the last 6 months of fiscal

[5] The total is less than 100 percent because a small number of bills (0.09 percent) have not yet been classified as to type of service involved.

[6] Under medical insurance the beneficiary has the right to offer assignment of Medicare payment to the physician or supplier. If the assignment is accepted, the physician or supplier may submit the claim for Medicare payment and receive payment directly. Under the terms of an assignment, the physician or supplier agrees to accept the carrier determination of reasonable charge as his total charge for the covered services, charging the beneficiary only for any unmet part of the $50 annual deductible and for 20 percent of the reasonable charge.

[7] Emergency hospital services are discussed in greater detail on pp. 61–63.

1967, when the benefit first became available. On the average, there was about one extended care facility admission for covered posthospital care for every 12 hospital admissions. The average number of covered days of extended care services per admission was approximately 45 days.

In Medicare's second year, an estimated $330 million was paid to extended care facilities for extended care services. Average reimbursement was $321 per recorded extended care claim.

Home health services

In Medicare's second year, there were nearly 260,000 "start of care" notices for home health services under both programs—an increase of 30,000 over the previous year. These represented about 13 notices per 1,000 persons covered under the program.

During the period, an estimated $50 million was paid for home health services under both the hospital and medical insurance programs. Average payment per recorded claim was $69 under hospital insurance and $42 under medical insurance.

Outpatient hospital services

During fiscal 1968, slightly over 3 million outpatient hospital bills were paid under Medicare. Total payments to hospitals for covered outpatient services amounted to an estimated $50 million. For services on or after April 1, 1968, both outpatient diagnostic and therapeutic services have been reimbursable only under medical insurance.

Physicians' services

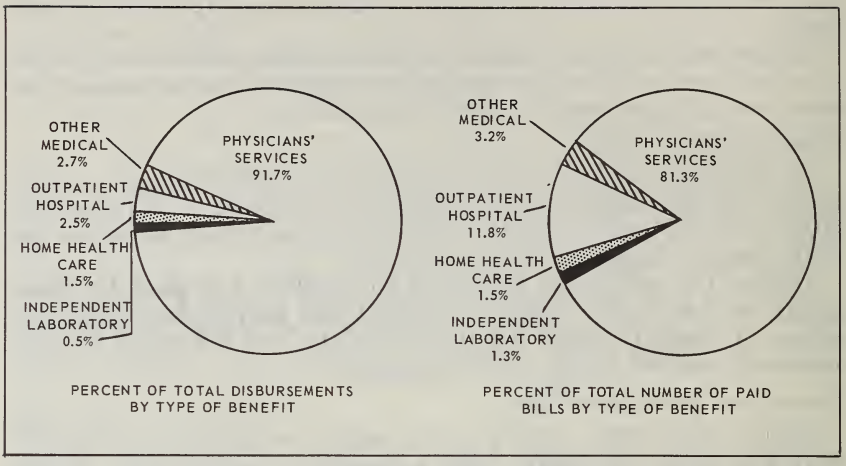
Of the 24.5 million bills for physicians' services approved for payment and recorded in Social Security Administration records during fiscal 1968, 13 percent were for surgical services and 87 percent were for medical services. Reasonable charges for surgical bills amounted to $535 million and averaged $166 per bill; for medical bills, they amounted to $1 billion and averaged $49 per bill.

The proportion of reasonable charges reimbursed by the program for physicians' surgical and medical services was 75 and 71 percent, respectively. A larger proportion of the reasonable charges for surgical services was reimbursed because the total charges for such services are characteristically higher than for medical services; hence, the $50 deductible represents a smaller proportion of the total.

Other medical services and supplies

During fiscal 1968, there were 1.4 million paid bills recorded for nonphysician medical services, other than home health and outpatient hospital services. In the case of independent laboratory services, the average reasonable charge per bill was $21, while the comparable figure for "other" medical services was $48. Included in this latter category are rental or purchase of durable medical equipment, ambulance services, prosthetic devices, and certain other medical services and supplies.

PERCENTAGES, BY TYPE OF BENEFIT, OF TOTAL DISBURSEMENTS AND TOTAL NUMBER OF PAID BILLS UNDER MEDICAL INSURANCE – FISCAL YEAR 1968[8]



CLAIMS PROCESSING PERFORMANCE

During fiscal year 1968, intermediaries[9] continued to maintain a fairly stable claims processing operation. The ratio of clearances to receipts fell in a narrow margin between 96.8 percent and 102.8 percent during the fiscal year. Weeks work on hand never exceeded 1.4 weeks work any time during the year.

Primarily as a result of added claims responsibilities and the need for systems modifications in connection with the 1967 amendment changes, intermediaries encountered some claim processing delays in the second half of fiscal 1968. During this 6-month period, the ratio of clearances to receipts exceeded 100 percent only in the month of June. As a result, the backlog of unprocessed claims increased from 347,000 in the month of January 1968 to 424,000 as of June 30, 1968. The number of claims pending more than 30 days increased from a low of 39,800 in January to an end-of-year high of 98,100, which represented 23.1 percent of the total end-of-year backlog.

For inpatient hospital claims, although there was a net backlog reduction of only a few thousand claims, average processing time showed signs of improvement by the end of the year. The average processing time for inpatient claims fell from over 12 days at the beginning of fiscal 1968 to less than 11 days at the end of the year. However, the inclusion of all hospital outpatient services under the medical insurance program as of April 1, 1968, with the claims processing and systems changes which were required, produced some initial delays in this area of intermediary performance. By the end of June, 287,100 outpatient claims were pending, representing over two-thirds of the total intermediary backlog at the end of the fiscal year.

A summary of intermediary workload and performance indicators for fiscal year 1968 is shown in the following chart:

[8] Totals do not add to 100 percent because of a small percent of bills (0.09 percent) not yet classified as to type of service involved.

[9] The program functions of intermediaries are described on p. 35. The intermediary claims process is discussed in detail on pp. 38–42.

WORKLOADS AND PERFORMANCE INDICATORS FOR INTERMEDIARIES (JULY 1967 TO JUNE 1968)

	Claims received	Claims cleared	Claims pending	Ratio of clearances to receipts (percent)	Weeks of work pending *	Percentage of unprocessed claims pending over 30 days
July	1,075,000	1,089,000	339,000	101.3	1.2	15.1
August	1,216,000	1,212,000	343,000	99.7	1.3	12.1
September	1,104,000	1,135,000	312,000	102.8	1.1	14.6
October	1,271,000	1,291,000	292,000	101.6	1.0	14.4
November	1,201,000	1,180,000	313,000	98.2	1.1	16.5
December	1,091,000	1,097,000	307,000	100.6	1.1	14.7
January	1,263,000	1,223,900	347,000	96.8	1.2	11.5
February	1,265,000	1,230,000	382,000	97.3	1.3	11.9
March	1,278,000	1,259,000	401,000	98.5	1.3	12.3
April	1,369,000	1,341,000	429,000	97.9	1.4	12.1
May	1,429,000	1,414,000	444,000	99.0	1.4	17.4
June	1,285,000	1,305,000	424,000	101.5	1.3	23.1

In fiscal year 1968, carriers[10] received 34,165,000 claims. Prior to December 1968 carriers were able to process claims at about the same rate as they were being received, as shown by the backlog of 1,439,000 claims in July and 1,409,000 at the beginning of December (which represented 2.3 weeks of work on hand). This progress came to an end in December, when beneficiaries who had been accumulating their medical bills during calendar 1967 began submitting them to carriers. Almost 1,000,000 more claims were received by carriers in January than in the month of November. By the end of January, the backlog grew to 2,554,000 claims, equal to 3.9 weeks of work on hand. However, as receipts slowly began to ebb during the February–June period, average monthly production reached 3,155,000 claims, an increase of almost 20 percent over the 2,647,000 average monthly output during the October–January period. As a result of the improved production rate, carriers reduced their pending by 716,000 claims in the February–June period and completed the fiscal year with a backlog of 1,838,000 claims, an equivalent of 2.6 weeks of work on hand.

A summary of carrier workloads and performance indicators for fiscal 1968 is shown in the following chart.

WORKLOADS AND PERFORMANCE INDICATORS FOR CARRIERS (JULY 1967 TO JUNE 1968)

	Claims received	Claims cleared	Claims pending disposition	Ratio of clearances to receipts (percent)	Weeks of work pending *	Percentage of unprocessed claims pending over 30 days
July	2,373,000	2,432,000	1,439,000	102.5	2.4	16.7
August	2,591,000	2,774,000	1,256,000	107.0	2.1	15.2
September	2,368,000	2,354,000	1,270,000	99.1	2.2	16.6
October	2,710,000	2,672,000	1,307,000	98.6	2.2	14.3
November	2,695,000	2,594,000	1,409,000	96.2	2.3	12.4
December	2,825,000	2,437,000	1,797,000	86.3	2.9	11.8
January	3,644,000	2,886,000	2,554,000	79.2	3.9	11.7
February	3,012,000	3,027,000	2,540,000	100.5	3.5	14.3
March	3,044,000	3,380,000	2,318,000	111.0	2.9	19.7
April	3,126,000	3,258,000	2,159,000	104.2	2.9	20.4
May	3,068,000	3,241,000	1,995,000	105.6	2.7	25.2
June	2,710,000	2,867,000	1,838,000	105.8	2.6	23.9

* Determined by dividing the average weekly production for the month into the claims pending at the end of the month.

[10] The program functions of carriers are described on p. 36. The carrier claims process is discussed in detail on pp. 42–46.

FINANCIAL EXPERIENCE

Under the Social Security Act, the Federal hospital insurance trust fund and the Federal supplementary medical insurance trust fund are held by two boards of trustees, each comprised of the same three members who serve in an ex officio capacity. The Secretary of the Treasury is designated by law as the managing trustee of both funds. The other members of each board are the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Commissioner of Social Security is secretary of both boards. The two trust funds were established on July 30, 1965, as separate accounts in the U.S. Treasury to hold the amounts accumulated under the respective programs.[11]

Hospital insurance trust fund

The major sources of receipts of the Federal hospital insurance trust fund are:

(1) amounts appropriated to it on the basis of contributions paid by workers and their employers, and by individuals with self-employment income, in work covered by the hospital insurance program;

(2) amounts deposited in it representing appropriations from general revenues to reimburse the fund for any expenditures on behalf of individuals not insured on the basis of social security or railroad retirement coverage but, nonetheless, entitled to hospital insurance protection under the "transitional insured status" provisions of section 103 of the Social Security Amendments of 1965.

Total receipts of the trust fund amounted to $3.902 billion in fiscal year 1968. In addition to contributions of $3.558 billion, receipts consisted of $61 million in interest from investments and $284 million reimbursed from the general fund of the Treasury.

Total disbursements from the trust fund in fiscal year 1968 amounted to $3.815 billion. Of this amount, $3.736 billion was paid out for benefits, based on Treasury statements. The remaining $79 million was for administrative expenses, which represented 2.1 percent of benefit disbursements.

The excess of total income over total outgo, amounting to $87 million, increased the total assets of the trust fund from $1.343 billion on June 30, 1967, to $1.431 billion on June 30, 1968.

The 1967 amendments raised the maximum amount of earnings taxable and creditable toward benefits to $7,800, beginning January 1, 1968. In addition, the schedule of contribution rates for hospital insurance was revised upward, as shown in the following chart, to continue to reflect the intent of Congress that the program be self-supporting on a long-range basis.

[11] The board of trustees issues annual reports on the status of the two trust funds, published as House documents of the U.S. Congress. See appendix E for a list of reports currently available.

EMPLOYER-EMPLOYEE, EACH

Period	Old law			New law		
	RSDI	HI	Total	RSDI	HI	Total
1968	3.9	0.5	4.4	3.8	0.6	4.4
1969–70	4.4	.5	4.9	4.2	.6	4.8
1971–72	4.4	.5	4.9	4.6	.6	5.2
1973–75	4.85	.55	5.4	5.0	.65	5.65
1976–79	4.85	.6	5.45	5.0	.7	5.7
1980–86	4.85	.7	5.55	5.0	.8	5.8
1987 and after	4.85	.8	5.65	5.0	.9	5.9

SELF-EMPLOYED PEOPLE

Period	Old law			New Law		
	RSDI	HI	Total	RSDI	HI	Total
1968	5.9	0.5	6.4	5.8	0.6	6.4
1969–70	6.6	.5	7.1	6.3	.6	6.9
1971–72	6.6	.5	7.1	6.9	.6	7.5
1973–75	7.0	.55	7.55	7.0	.65	7.65
1976–79	7.0	.6	7.6	7.0	.7	7.7
1980–86	7.0	.7	7.7	7.0	.8	7.8
1987 and after	7.0	.8	7.8	7.0	.9	7.9

Supplementary medical insurance trust fund

The major sources of receipts of the Federal supplementary medical insurance trust fund are—

(1) Amounts deposited in or transferred to it with respect to the premiums paid by persons aged 65 or over who elect to participate in the program, including payments made by States on behalf of assistance recipients for whom the State has elected to "buy in" for medical insurance coverage; and

(2) The premium matching payments of the Federal Government that are authorized to be appropriated and transferred to the trust fund from general revenues.

Premiums collected in fiscal year 1968 amounted to $698 million, including $53 million representing payment for "buy-in" States for assistance recipients enrolled by these States. The matching contributions from the general fund of the Treasury amounted to $634 million, which includes a deficiency of $24 million in Government matching funds made up from fiscal year 1967. A deficiency of $88 million in Government matching funds remained at the end of fiscal 1968.

Total receipts of the trust fund from all sources amounted to $1.353 billion in fiscal year 1968. In addition to premiums and matching payments, receipts consisted of $21 million in interest from investments. Total disbursements from the trust fund in fiscal year 1968 amounted to $1.532 billion. Of this amount, $1.390 billion was paid out for benefits, based on Treasury statements. The remaining $143 million was for administrative expenses, which represented 10.2 percent of benefit disbursements.

The excess of total outgo over total income, amounting to $179 million, decreased the total assets of the trust fund from $486 million on June 30, 1967, to $307 million on June 30, 1968.

Effective April 1, 1968, the monthly premium rate was increased from $3 to $4, with the Government contributing an equal amount.[12] This rate will remain in effect until June 30, 1969. The 1967 amendments require the Secretary, beginning in 1968, to establish and announce premium rates before the end of December. The new rate, if there is a change, becomes effective the following July 1.[13]

[12] The actuarial bases and assumptions for this premium increase are shown in app. B.
[13] On Dec. 31, 1968, the Secretary of Health, Education, and Welfare promulgated a continuation of the $4 premium rate for the period July 1, 1969, through June 30, 1970.

Chapter II. Program Administration

A. SUMMARY OF ADMINISTRATIVE STRUCTURE

Overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for significant participation in certain areas of administration by private organizations and public agencies, as well as for the establishment of a Health Insurance Benefits Advisory Council (HIBAC) to advise the Secretary on program administration.

Within the Department of Health, Education, and Welfare, primary responsibility for administering the Medicare program is assigned to the Social Security Administration. Special responsibilities in connection with the health care standards of Medicare have been assigned to the Public Health Service, and certain responsibilities in respect to the relationships between Medicare and State assistance programs are carried out by the Social and Rehabilitation Service. Responsibility for assuring necessary conformance by participating health care facilities to title VI of the Civil Rights Act of 1964 is assigned to the Office of Civil Rights of the Department.

Role of the Social Security Administration[1]

The Social Security Administration negotiates and administers agreements with the intermediaries and carriers which perform payment and other program functions, with the State agencies which certify health facilities for participation in the program, and with hospitals and other institutions which provide services for which the program makes reimbursement; develops reimbursement principles and guidelines; participates with the Public Health Service in the formulation of the conditions of participation; formulates Medicare regulations; develops program policy and procedural instructions; and performs the basic recordkeeping and data processing functions required for administration of the program. Within the Administration, the Bureau of Health Insurance has been assigned primary responsibility for the formulation of policies and procedures and for the overall administration of the health insurance program.

In addition to the Bureau of Health Insurance,[2] many other Administration components have substantial program responsibilities. The Administration's field organization—composed of nine regional offices, 779 district and branch offices, and 3,241 contact stations throughout the country—carries out enrollment activities and serves as a readily accessible source of basic program information and direct service to beneficiaries and to the general public.

The Office of Research and Statistics collects data on program operations and carries out analytical studies designed to evaluate the program and measure its performance.

[1] An organizational chart of the Social Security Administration is shown in app. B.
[2] An organizational chart of the Bureau of Health Insurance is shown in app. B.

The Office of the Actuary has responsibility for the actuarial evaluation of the hospital insurance and medical insurance programs, including the preparation of the actuarial estimates used in setting the medical insurance premium and hospital insurance deductible and coinsurance amounts.

The Office of Information, which has primary responsibility for developing and coordinating the administration's informational activities, works with the Bureau of Health Insurance in the preparation of exhibits, films, visual aids, booklets, and other materials needed to inform the general public, as well as special professional audiences, about program provisions and claims procedures.

The Bureau of Data Processing and Accounts, through its electronic data processing capabilities, maintains the millions of records on beneficiary eligibility, utilization of covered services, and deductible status. The Bureau also sends premium notices to, and maintains records on the payment of medical insurance premiums by, the approximately 3¼ million enrollees who make direct payments or for whom premium payment is made through State agency "buy-in" arrangements or through private retirement groups.

An insurance compliance staff in the Office of Administration assures that the intermediaries and carriers assisting in the administration of Medicare fully comply with the equal employment opportunity requirements of Executive Order 11246.

Role of the Public Health Service

The Department's Public Health Service acts as a primary resource in the professional health aspects of the Medicare program, participating with the Social Security Administration in formulating the conditions of participation for providers of services, developing policies on the role of State agencies, providing assistance to the State agencies in carrying out their Medicare responsibilities, supporting and evaluating experimental approaches to utilization review, and providing professional advice in many technical and medical areas of program administration.

Role of the Social and Rehabilitation Service

The Social and Rehabilitation Service collaborates with the Social Security Administration and the Public Health Service in those aspects of program planning, coordination, and evaluation involving the interrelationships of the health insurance program with State public assistance and medical assistance programs. In addition, the Social and Rehabilitation Service provides consultation and general and technical assistance to State agencies administering medical assistance programs to assure effective coordination between Medicare and the programs at the State level.

Role of the Office of Civil Rights

Title VI of the Civil Rights Act of 1964 provides that no institution, agency, or activity receiving Federal financial assistance may engage in discriminatory practice on the basis of race, color, or national origin. Thus, before any hospital, extended care facility or home health agency may be a participating provider under Medicare, their compliance with the provisions of title VI must be assured. The DHEW

Office of Civil Rights establishes such compliance for all Medicare providers and investigates all complaints relating to discrimination.

Role of the State agencies [3]

The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of services and independent laboratories meet the conditions for participation in the Medicare program. All 55 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) have designated agencies—in most instances State health agencies—to perform this function.

In carrying out their responsibilities under the health insurance program, the State agencies conduct field surveys of institutions and agencies to determine the extent to which these facilities meet the applicable conditions of participation, undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions, provide consultative services to facilities experiencing difficulties in meeting the participation requirements, identify nonparticipating hospitals which can be reimbursed under the program for emergency services, and coordinate activities under the health insurance program with activities conducted under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program including related costs of administrative overhead and staff.

Role of the intermediaries [4]

Participating hospitals, extended care facilities, and home health agencies may either receive program reimbursement through a fiscal intermediary or, if they prefer, receive payment directly from the Government. Virtually all providers have chosen to deal through intermediaries. Under agreements with the Secretary of Health, Education, and Welfare, the intermediary is responsible for determining the reasonable costs of services provided to beneficiaries and for reimbursing providers for these costs on behalf of the program. In addition, the agreements authorize the intermediary to provide consultative services to providers, to make audits of provider records, and perform related functions. All agreements also require that the intermediary must assist providers in establishing and applying safeguards against the unnecessary use of services covered under the program. As of June 30, 1968, the Blue Cross Association (with subcontracts to 74 Blue Cross plans), five commercial health insurers, five independent insurers and one State agency were operating as fiscal intermediaries on behalf of over 13,000 participating providers.[5] Two hundred thirty-six hospitals, 35 extended care facilities and 29 home health agencies were submitting bills directly to SSA.

[3] A list of State agencies having agreements with the Secretary of Health, Education, and Welfare under the Medicare program is shown in app. B.

[4] A list of intermediaries operating under agreements with the Secretary of Health, Education, and Welfare is shown in app. B.

[5] The Blue Cross Association (with subcontracts to 74 Blue Cross Plans) acts as fiscal intermediary for 91 percent of participating hospitals (and for all nonparticipating hospitals submitting emergency claims), for 87 percent of participating home health agencies and for 51 percent of participating extended care facilities.

Role of the carriers [6]

For making payments under the medical insurance program, the Secretary is required by law to, wherever possible, contract with organizations already engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or similar group arrangements, in return for premiums or other periodic charges. The selected carriers determine the amounts to be paid to physicians and to suppliers for services rendered under the program and make payments for such services on behalf of the program, and, under the terms of their contracts with the Secretary, are required to assist in the application of safeguards against the unnecessary utilization of services, and to serve as a channel of communication for information relating to the administration of the program.

As of June 30, 1968, there were 33 Blue Shield plans, 15 insurance companies, one independent health insurer and one State agency operating as carriers.

Activities of the Health Insurance Benefits Advisory Council and other consultative groups

Since its enactment in 1965, the Medicare program has drawn on the consultative assistance of many groups of experts representing every public or professional interest that would be affected by the program. In addition, the Social Security Administration has had continuing contacts with individuals at all levels in the health field, the insurance industry and from the general public, either to solicit their expert advice or opinions, or in response to their submittal of ideas and recommendations for program improvement.

Health Insurance Benefits Advisory Council

Of the various consultative groups, the Health Insurance Benefits Advisory Council, which was established by the original Medicare law, has had by far the most important consultative role on Medicare policies and procedures. Originally the Council consisted of 16 private citizens including leaders in the health care field and representation from the general public. In its advisory capacity, the Council has advised the Secretary with respect to every major policy and procedure affecting program implementation. Since its formation in November 1965, through June 1968, HIBAC has held 30 meetings lasting at least 2 and sometimes 3 days.[7]

The Social Security Amendments of 1967 contained provisions which affected not only the size but also the functions of HIBAC. The most important was the transfer of all functions of the National Medical Review Committee (which had not been appointed) to HIBAC. To meet these increased responsibilities, the size of the Council was increased from 16 to 19. Thus, in addition to its other title XVIII responsibilities, the Council has assumed the statutory mandate "to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the pro-

[6] A list of carriers under contracts with the Secretary of Health, Education, and Welfare is shown in app. B.

[7] A list of HIBAC membership appears in app. B.

grams established by this title, or in the provisions of this title." [8] In addition, the 1967 amendments require HIBAC to submit an annual report on the performance of its functions to the Secretary of HEW for transmittal to Congress, and to engage such technical assistance as required to carry out its functions.

To meet its new responsibilities, the Council established an ad hoc committee on the evaluation of the delivery and use of services (CEDUS). In addition, to support the committee, the Council created task forces in the following areas: research and statistics; hospital and extended care services; home health services; medical services; and laboratory services.

Each task force has been reinforced by consultants appointed to provide their expert advice and to bring to HIBAC the views of important groups and organizations. Included among the consultants have been representatives of organized medicine, institutional providers, the insurance field, and consumer organizations.

Other consultative groups

In fiscal 1968, two special advisory groups were established to implement important mandates growing out of the 1967 amendments. The first was a 12-member advisory council to study coverage of the disabled under Medicare. The Congress requested that a report of the findings and recommendations of this council be submitted to the Secretary of Health, Education, and Welfare by January 1, 1969.[9] The second group was a 16-member advisory panel appointed to furnish assistance in reviewing proposals for incentive reimbursement experiments. Such experimentation, authorized by the 1967 amendments, is designed to test alternative methods of reimbursing providers and physicians, under Medicare and other Federal health programs, which might lead to increased efficiency and economy in providing health services without adversely affecting their quality.[10]

A particularly important ad hoc advisory group was also established in fiscal 1968 on the recommendation of HIBAC. The Council expressed great concern over the increasing escalation of charges for services under the medical insurance program and recommended that a special group of experts be established to work with the Bureau of Health Insurance in a comprehensive review of Bureau policies on reasonable charge determination and on the carriers' application of statutory, regulatory, and administrative provisions. As a result, an ad hoc work group on reasonable charge determination methodology was established in April 1968.[11]

There are, finally, three continuing advisory groups, which were established in the first year of Medicare operation to assure effective coordination between the Bureau of Health Insurance and the intermediaries and carriers regarding policies and procedures which have an impact on their program administration responsibilities. These three groups whose representative activity is undertaken on behalf of the entire group of intermediaries and carriers are: the Blue Cross

[8] Section 1867(b)(2) of the Social Security Act, as amended.
[9] The report was presented to the Secretary in December 1968 and transmitted to the Congress on Jan. 3, 1969.
[10] Incentive reimbursement experimentation activities are discussed in detail on pages 58–60. A list of advisory panel members appears in appendix B.
[11] A list of members of the work group appears in appendix B.

advisory group, representing all Blue Cross plans; the fiscal intermediary group, representing all fiscal intermediaries other than the Blue Cross plans; and the carrier representative group representing all 50 carriers. Representative group meetings are held on a regularly scheduled quarterly basis. The consultative activity of these groups was broadened during fiscal 1968 to provide for earlier involvement by the entire group, or by panels of experts selected by the group, in the development of Bureau policies and procedures on technical issues.

B. INTERMEDIARY AND CARRIER PERFORMANCE

From the point of view of beneficiaries and the health community, as well as the public at large, the performance of Medicare is substantially the performance of intermediaries and carriers. It is their effectiveness in processing claims, in communicating program policies and procedures to the public and in establishing relationships with the health community, which shapes the public and professional response to the program.

Substantial improvements were achieved in fiscal 1968 in the promptness with which claims were handled, in the development of more efficient claims procedures, in manpower productivity and in the reduction of claims processing costs. It should be noted that much of this improvement is attributable to the initiative and imagination of the intermediaries and carriers in solving problems of procedure and operation in the face of extremely heavy workloads. Within general guidelines issued by the Social Security Administration, the intermediaries and carriers are responsible for developing effective administrative mechanisms for achieving the required program results. This has led to a number of different patterns in the internal administration and Medicare operations of the intermediaries and carriers. Much of the success of Medicare, particularly its growing acceptance by the health community, is attributable to the opportunities presented by such an administrative pattern for intermediaries and carriers to develop uniquely responsive mechanisms to meet the variable patterns in the Nation's health care system.

Description of the intermediary claims process

The intermediary claims process consists basically in determining the amount of program reimbursement which is due to providers for covered services furnished to Medicare beneficiaries and in making periodic payment of those amounts to providers.[12] There are two aspects of the intermediary claims process which deserve special note. First, program reimbursement to providers is payment for the reasonable costs of furnishing covered services to the aggregate of beneficiaries receiving such services from the provider over a fiscal period (usually the provider's accounting year)—not payment on behalf of each beneficiary for the covered services he receives as an individual patient. Thus, in the intermediary claims process, the provider, rather than the beneficiary, is always the claimant. Each claim, in effect, is a bill record of services rendered, which is accumulated with all other such records from that provider until the end of its accounting period when a final cost settlement is made for all covered services rendered

[12] The reasonable cost basis for provider reimbursement and the methods of payment are described on pages 51–55.

by the provider in that accounting period. Interim payments, in amounts related to bills submitted by the provider, are made throughout the accounting period, subject to adjustment on the final settlement for that period.

Secondly, there is no continuing relationship between a given intermediary and an individual beneficiary. A relationship is established only when a beneficiary receives services from a provider whose payments are handled by that intermediary. The beneficiary, at some other point of time, may receive services from a different provider represented by a different intermediary. Thus, no single intermediary can maintain a full record of any beneficiary's use of hospital insurance services. Since, in general, a beneficiary's current eligibility for provider services depends upon the extent of his recent utilization of other provider services, anywhere in the Nation, it is necessary to maintain a master utilization record so that prior utilization information can be made immediately available as needed. A master utilization record was, therefore, established within the Social Security Administration to which intermediaries are linked by wire communications for rapid query of the central records whenever eligibility and deductible status information is required.

The basic steps in the intermediary claims process can be briefly summarized as follows: For inpatient hospital, extended care, and home health services, when a Medicare beneficiary is admitted to a participating hospital or extended care facility, or begins a plan of care from a home health agency, the provider sends the intermediary an admission or start-of-care notice. The intermediary queries the Social Security Administration's central record system, which replies giving the patient's entitlement and deductible status, and remaining eligibility for benefits. The intermediary then advises the provider of the patient's eligibility for further benefits and his deductible status. Admission and start-of-care notices are sent to the Social Security Administration by teletype or, in some instances, on magnetic tape, or by direct magnetic tape to magnetic tape transmission over high-speed wires. Replies can usually be sent to the intermediary on the second working day after a request for eligibility information has been made.

During the course of treatment, or after beneficiaries are discharged from the hospital or extended care facility or complete a course of home health treatments, the provider submits claims to the intermediary for interim payment, subject to final settlement at the end of the accounting period. Utilization data are forwarded to the Social Security Administration so that the central records may be updated to provide accurate information in replying to subsequent notices of admission or starts of home health care. As part of the updating process, explanation of benefit notices are prepared and sent to the beneficiaries to inform them of services paid for by the program and the balance of inpatient days or home health visits for the current benefit period.

For outpatient hospital benefits (and other services furnished by providers which are covered under the medical insurance program), claims are submitted to the intermediary, usually upon completion of services. Since eligibility for payment and the determination of the amount payable depend upon the deductible status of the beneficiary, the intermediary queries the Social Security Administration central records for deductible status. (If, on the basis of a previous

query for other covered part B services, the intermediary has already been advised that the deductible has been met, the intermediary does not need to make a further request for the remainder of the calendar year.) The intermediary then computes the amount of payment due the provider and makes payment on the basis of reasonable cost. A record of payment is transmitted to the Social Security Administration and an explanation of benefits is sent to the beneficiary.

Under a special provision of the 1967 amendments, hospitals are allowed to collect the full amount of outpatient charges from a beneficiary if they are $50 or less, when they cannot determine his deductible status at the time of collection. Where such a payment is made by the beneficiary and the subsequent query reply from the Social Security Administration indicates that all or part of the deductible has previously been met, the intermediary can make payment directly to the beneficiary to compensate for the amount of his overpayment to the provider. Such beneficiary overpayments to the provider are taken into account in the final cost settlement by the intermediary at the end of the provider's accounting period.

Improvements in the intermediary claims process

The intermediary claims process showed substantial improvement during Medicare's second year, as many of the early operational problems were resolved. By the end of fiscal 1968 the claim processing time for inpatient hospital claims—the largest portion of their workload—was reduced to slightly less than 11 days. Combined with the fact that virtually all intermediaries by the end of the year were making interim payments to providers at intervals of 1 week or less, there have been very few problems among providers regarding cash flow.

Some initial problems developed in processing outpatient hospital claims, however. The 1967 amendments provided that effective on and after April 1, 1968, all outpatient services would be covered only under the medical insurance program. Prior to April 1, outpatient hospital diagnostic services were covered under hospital insurance, with a complex deductible provision and a time limitation which was difficult to administer. The 1967 amendment change greatly simplified outpatient coverage for beneficiaries and significantly reduced billing problems for hospitals. Because of required intermediary claims processing and systems changes, a backlog of unprocessed outpatient claims began accumulating shortly after April 1, but steadily improving intermediary capacity toward the end of the fiscal year permitted processing of these claims within 30 days on the average.

A total of 13,529,200 claims were processed in fiscal 1968—an increase of 4,574,100 or 51.1 percent over the preceding year. With the increase of workloads in fiscal 1968, intermediary manpower needs also were greater as reflected by a 43 percent increase in staff (excluding audit staff) over the prior year. The smaller percentage increase in manpower compared with the increase in claims processed reflects improved productivity per man-year, which advanced by 5.6 percent, to 2,715 claims processed per man-year. At the same time, the unit cost of processing a claim dropped from $3.36 in fiscal 1967 to $3.13 in fiscal 1968—a reduction of 6.8 percent.

Comparisons between 1967 and 1968 in significant areas of administrative performance by intermediaries are shown in the following table:

Part A intermediaries (excluding provider auditing)	Total fiscal year 1967	Total fiscal year 1968	Net difference	Percent change
Claims processed	8,955,100	13,529,200	4,574,100	51.1
Administrative cost	$30,122,000	$42,284,000	$12,162,000	40.4
Average manpower	3,485.0	4,983.0	1,498.0	43.0
Unit cost	$3.36	$3.13	−$.23	−6.8
Productivity per man-year	2,570	2,715	145	5.6

It should be noted that fiscal 1967 represented the beginning of the program when extensive amounts of time were spent acquiring necessary staff and equipment and in establishing effective claims procedures. During the first half of fiscal 1967, there was not a significant workload because of the lag between discharges and submission of bills by providers. It took about 6 months for the pipeline to fill so that claims were flowing into the intermediaries on a steady basis. In addition, extended care coverage did not begin until the second half of fiscal 1967. Consequently, the comparisons in the above table must take into account that fiscal 1968 was the first full year of normal operations and that fiscal 1967 is not a representative base year.

One of the most intensive areas of intermediary activity during the year was in securing cost reports from the providers for their first accounting period. Most intermediaries have encountered difficulties in this area, primarily because for many providers this has been their first experience in submitting such detailed cost statements. As the fiscal year progressed, intermediary efforts began to show results. As of June 30, 1968, intermediaries had received 83 percent of the 6,800 hospital cost reports due for the first accounting period.

Upon receipt of cost statements, intermediaries are required to undertake an audit review of each statement, either through their own resources or under contracts with private firms. By June 30, 1968, audits had been initiated on almost 80 percent of the cost reports received. Field audits had been completed on a little over 60 percent of those started, and final settlements had been made on slightly over 40 percent of the audited hospital cost reports.

As the audit program progressed, problems were identified which were retarding the rate of audit completion. Tailoring an audit program which is applicable to providers whose size and recordkeeping capability varied widely posed several policy and procedural problems. The need to perform Medicare audits for over 13,000 providers (hospitals, home health agencies, and extended care facilities) has placed a considerable burden on the existing audit capability of the Nation. The newness and scope of the Medicare audit program precluded as rapid implementation as desirable in fiscal year 1968.

Intermediaries and the Social Security Administration, with counseling assistance from groups such as the American Institute of Certified Public Accountants (AICPA) and the American Hospital Association (AHA), directed their resources toward resolution of these

problems. Studies were made to determine causes for delays at various stages of the audit cycle. As a result of these studies, modifications have been made in the policies and procedures which are designed to simplify and expedite provider audit activity. While there remain areas in which further modifications are to be made, a number of steps were taken in fiscal year 1968 to expedite filing of cost reports, to improve audit subcontracting procedures, and to tailor the scope of audits to the needs of individual providers.

Special open item project

Although it affects only a small number of claims, one of the most difficult operational problems in the intermediary process in fiscal 1968 was that of open items. Because a beneficiary's current eligibility for hospital insurance benefits is determined by his prior use of such benefits, providers need to confirm how much eligibility a beneficiary has before they can be assured of payment for the services they will render. Thus, for every admission or start of care notice from the provider, the intermediary queries the central record system in Baltimore to determine the number of days of care or home health visits for which the patient is currently eligible. Unless the central record system has received a hospital or extended care facility discharge notice or termination of home health care notice for any previous services in the same benefit category, it must reply to the query by indicating that a prior admission or start of care entry has not been closed and the current eligibility status of the beneficiary for additional services of that type is not reportable. When such open items occur, a considerable additional effort is involved in establishing a completed record for the prior service. In many cases the discharge or termination of care has long since occurred, but the proper notice has not been transmitted from the intermediary to the central record system, due to delays in final bill submittal or timelags involved in bill processing, transmission to the central record, or data recording.

A special study was undertaken in the spring of 1968 to determine whether hospital submittal of a punchcard notice directly to the central record system at the time of discharge could significantly reduce the open item problem. All hospitals in Connecticut cooperated in the study. Analysis of the data is not yet complete, but preliminary indications are that the procedure can substantially reduce the time period between discharge and the computer entry of this information, without any undue burden on providers or added complexity in the intermediary claim process. Planning is now underway to apply the new procedure on a national basis before the end of fiscal 1969.

Description of carrier claims process

The carrier receives all claims for reimbursement of reasonable charges for physicians' services and other covered medical services reimbursable on a charge basis. These claims may or may not be accompanied by copies of physicians' or suppliers' bills, depending upon whether the beneficiary completes the claim form himself and attaches bills he has received or whether the claim is completed by the physician or supplier under assignment or as an assistance to the claimant. Every claim received by the carrier requires two determinations in respect to each distinct service furnished the beneficiary. First, a determination must be made as to whether the service is covered. If the service is

covered, then a determination must be made as to the reasonable charge for that service. The efficiency of the carrier claims process is, therefore, greatly dependent upon securing detailed itemization of services rendered as well as the carrier's maintenance of accurate and current information concerning independent physician and supplier charge patterns for similar services to other patients in the same locality.

To assure completeness of claims, the carriers, through a continuing professional relations program with physicians and their office assistants, have encouraged the completion of claim forms in the physician's office whether or not the physician takes assignment. On a national basis, for June 1968, 61.8 percent of the claims received involving physician services (other than hospital-based physicians), were taken on assignment. In accepting assignment, the physician agrees to accept the reasonable charge determined by the carrier as his full charge for the services involved. Some physicians accept assignment for all bills rendered Medicare beneficiaries while others accept assignment in individual situations.

The basic steps in the carrier claims process can be briefly summarized as follows: Upon receipt of claims, controls are established to assure proper disposition and to permit location of claims in the event of inquiry. Claims are reviewed for coverage of services and for completeness of information and are then moved on for the determination of reasonable charges. This is accomplished by comparing the bill charges with customary charges of the physician for such services and the prevailing charge established in the locality for similar services. Increasingly, this action is accomplished through a computer process in order to handle the volume of claims expeditiously and economically.

It should be noted that each carrier receives claims for payment of medical insurance benefits provided by physicians or suppliers located within its geographic area. This continuity of relationship between the carrier and the physicians and suppliers in a geographical area is essential for the establishment and maintenance of customary and prevailing charge data.

As in the hospital insurance program, SSA maintains a master eligibility and utilization record of all medical insurance enrollees. An important step in the claims process requires the carrier to determine current eligibility of the claimant for benefits and whether or not the claimant has met the current year deductible. If the carrier has processed claims for services to the individual beneficiary earlier in the year, it may have information in its history file regarding the status of the deductible. If not, it queries the SSA master record transmitting essential identifying information and the amount of the reasonable charge, using the same transmittal facilities as are available for intermediaries in Part A. SSA in updating the master record responds to the query, generally within 24 hours, verifying eligibility and identifying the amount of the deductible remaining to be satisfied. The carrier then makes the appropriate payment to the physician or supplier if an assignment has been taken or, if not, to the beneficiary. An explanation of the action taken on the claim, and the computation of the benefit payment, if any, is sent to the beneficiary, and in assignment cases, to the physician or supplier with a copy to the beneficiary.

Improvements in the carrier claims process

Generally speaking, by the end of Medicare's second year, the carrier staffs were more experienced and better trained. Also, most of the earlier major systems and procedural problems involved in the basic claims processing operations were sufficiently resolved so that, for most carriers, acceptable levels of productivity and claims processing time had been achieved.

Carriers during fiscal 1968 were, therefore, able to devote greater attention to refining and perfecting more sophisticated systems, and several carriers which up to that time had relied on entirely manual operations began to convert to partial or completely automated claims processing systems. Effective electronic data processing systems will enable carriers to further reduce claims processing time and thereby improve service to beneficiaries as well as to eventually realize administrative cost savings through the efficiency of automated systems. In addition, such systems can, far more efficiently than manual systems, incorporate quality control indicators as management devices to aid in achieving more effective administration.

A great deal of emphasis during fiscal 1968 was placed on insuring that there were adequate safeguards in every carrier's system to detect duplicate claims and thereby prevent duplicate payments. The broad range of covered services and large volumes of claims under Part B, the provisions for assigned and nonassigned claims, and the advanced age of the beneficiaries which sometimes leads to confusion as to claims form completion and submittal, all combine to create a potential for duplicate claims and payments not ordinarily found in other health insurance programs. While all carriers had some duplicate claims detection procedures established prior to Medicare in respect to their private programs, many such systems had to be improved or revised to make them adequate to meet the increased demands occasioned by the Medicare program. SSA participated in experimenting and testing with different carriers to determine the most effective type of computerized screens to detect duplicate claims, and also to identify the major causes of duplicate claims so that eventually, instead of relying on detecting duplicate claims upon receipt, they can be cut off at the source. During fiscal 1968, after consultation with the carrier representative group, SSA issued criteria which carriers were to follow in structuring duplicate claims detection systems and at the same time established a reporting system under which carriers will furnish SSA information on their progress in implementing their systems and on the volume of duplicate claims detected. This, combined with soon-to-be-initiated claims processing validation tests and SSA's continuing carrier performance reviews should substantially reduce the duplicate payment problem.

The progress of all of the 50 carriers in establishing effective claims systems and improving their level of general performance has not, of course, been the same. There were some carriers which experienced unique or greater problems during the "tooling-up" period and which, consequently, had difficulty in keeping workloads current during the early months of the program. In certain areas of the country carriers were faced with shortages of experienced personnel when recruiting and consequently it took these carriers longer to train their staffs. Some carriers experienced unexpected problems when converting from man-

ual to automated systems which they eventually overcame, but the time required varied. Still others were faced with unexpected heavy workloads. Toward the end of fiscal 1968 there were a few carriers whose performance could be considered to be at best still only marginal, and SSA had to decide whether to continue the contracts with these few carriers. After considering all of the factors involved, the decision was made to renew the contracts with these few marginal carriers for at least the first 6 months of fiscal 1969.

The decision to renew a particular carrier's contract is not primarily related to the availability of a capable organization willing to handle the particular workload. As witnessed by the 140 proposals originally received from a variety of health insurance organizations to serve as carriers, there are many willing organizations which are available to serve as carriers. However, the matter of introducing a new organization to replace a carrier—or even to assume part of its workload—is a step which would not be without significant problems even if the new organization were one which was already serving as a carrier in another area. Any new carrier would have to overcome the same "tooling-up" problems that all carriers experienced originally (that is, hiring and training staff, acquiring equipment, and so forth) and these problems would be considerable and costly, notwithstanding SSA's and the replacement carrier's ability. In short, no organization has the instant capability to take over any carrier's workload.

Prior to their selections, the 50 organizations currently serving as carriers were evaluated very carefully and extensively at the time of selection against a set of criteria developed expressly to meet the needs of the Medicare program. These criteria include potential ability to process the expected volume of work, ability, and experience in determining reasonable charges for physicians' services, and the extent and substance of the organization's relations with the professional community in a particular geographic area. The 50 carriers selected had the greatest potential for doing the job based on their overall organization and experience, and while some carriers experienced greater difficulties than did others in discharging their responsibilities, it was felt that they had the potential to perform effectively. The results of the priority attention given to the few marginal carriers after their contract renewal appears to demonstrate, in most instances, that the decision to retain these carriers (as opposed to having risked seriously disrupting the program in replacing them) was a sound one.

Carriers processed a total of 33,779,200 claims in fiscal 1968, an increase of 96.7 percent over fiscal 1967's total of 17,177,000. Manpower, although increasing a significant 53 percent, was far under the percentage increase in the number of claims processed. Carriers generally had better trained staffs during the second year of operations, and many operating problems had been solved. This resulted in a gratifying gain in productivity per man-year to 2,915 claims—an increase of 28.5 percent over fiscal 1967. The unit cost decreased from $3.52 in fiscal year 1967 to $2.91 in fiscal year 1968—a reduction of 17.3 percent.

During the fourth quarter, unit costs increased somewhat over the third quarter while productivity per man-year declined. These changes reflect remedial actions by some carriers to improve the quality of

work—particularly in the areas of reasonable charge determinations, detection of duplicate payments, and improved case control systems.

In the following table, comparing fiscal year 1968 carrier processing results with the preceding year, it must be kept in mind that the first 6 months of fiscal 1967 was an abnormal period characterized by low workloads and high unit costs due to low productivity and recruiting and training activities. Thus, fiscal 1967 is not a representative "base year" against which fiscal 1968 activities can be accurately compared in all respects.

Part B carriers (including RR Board)	Total fiscal year 1967	Total fiscal year 1968	Net difference	Percent change
Claims processed	17,177,000	33,779,200	16,602,200	96.7
Administrative cost	$60,442,000	$98,178,000	$37,736,000	62.4
Average manpower	7,573.0	11,589.0	4,016	53.0
Unit cost	$3.52	$2.91	−$.61	−17.3
Productivity per man-year	2,268	2,915	647	28.5

Part B model system

The 50 part B carriers, operating in 77 locations, process Medicare claims through a variety of systems. Most carriers have employed computers and automated systems in an effort to reduce the paperwork and clerical operations required in processing the very large volume workloads resulting from Medicare. The automated systems vary in their design, effectiveness, and success in accomplishing program objectives. Many of the automated systems do an excellent job in one or more aspects, but no single carrier system as yet fully serves all program goals.

The few carriers who are not automated plan to do so at an early date. Many of the carriers with automated systems are planning to redesign their systems. And, as legislation, policy decisions, and administrative actions almost always require systems changes, there is constant activity in designing, redesigning, and programing carriers' systems. Costs of such activity are substantial in individual situations and quite large in the aggregate.

In an effort to reduce costs in the long run, and to make a model system available to carriers that have not yet achieved a fully effective automated processing system, the Administration, in collaboration with the Pilot Life Insurance Co. of North Carolina, has undertaken the development of a fully automated claim processing system. The system is being installed at Pilot and as soon as sufficient experience is gained, the model system will be made available at no further cost to other carriers. The system is being designed in modules, or segments, which can be installed one at a time, and the computer programs will be written in COBOL (COmmon Business-Oriented Language) so that they can be readily adapted for most makes of equipment.

Work on the model system has been on schedule so far and there is reasonable expectation that the first modules of the system will be in operation at Pilot in early 1969, with the total system installed and operating by June 1969.

All carriers have been kept informed of progress on the model system and many carriers have expressed strong interest in adopting all or part of the system as soon as it becomes available.

Improvement in the direct reimbursement claims process

The great majority of providers chose to receive Medicare payments through the selection of an intermediary. A few, however, did not exercise the option to designate an intermediary and, hence, deal directly with the Social Security Administration. Most of these providers represent State and municipal facilities and agencies operating as part of a governmental structure. As of June 30, 1968, 236 hospitals, 35 extended-care facilities, and 29 home-health agencies were submitting bills to the Social Security Administration. A direct reimbursement branch was established in the Bureau of Health Insurance to process this workload.

The direct reimbursement branch now processes approximately 1 percent of the national part A workload. Because the direct reimbursement branch has a carrier function only in respect to provider-based physician billings from governmental institutions, workload comparisons with other carriers is not meaningful. In fiscal year 1968, the direct reimbursement branch workload increased more than 180 percent from the preceding year, from 118,028 to 330,614 claims processed.

The processing of notices of admission and starts of care from direct dealing providers follows the same steps as in the intermediary process. The direct reimbursement branch encounters some special problems, however, because of the fact that most direct dealing providers have not regularly received insurance payments from third-party payers in the past and they are not, therefore, as experienced as other providers in submitting proper information, preparing required billings or maintaining necessary record systems. In addition, it is somewhat more difficult for the direct reimbursement branch to communicate directly with providers to clarify problem areas and to conduct training programs, as other intermediaries have, because they are so widely dispersed geographically in respect to the claims processing function in Baltimore. During fiscal year 1968, however, through the use of regional and district office personnel in personal contracts with direct dealing providers, the direct reimbursement branch made considerable progress in improving the accuracy of notices of admission and starts of care and in securing timely billings. A number of internal improvements have also been made in improving the claims review function of the direct reimbursement branch, through computerization of certain processing steps and intensive training of claims review staff.

All of these improvements resulted in a reduction of average claims processing time from 4.8 weeks at the beginning of fiscal year 1968 to 2.2 weeks at the end of the year.

Reviewing intermediary and carrier performance

The Bureau of Health Insurance has spent considerable staff time reviewing various indices of performance with intermediaries and carriers to assure that their operations are efficient and economical as well as, where necessary, to furnish assistance to those companies which, in one aspect or another, are not meeting performance standards. Four separate closely coordinated plans have been established for covering specific aspects of total operations. The four systems are: performance review, contractor operations analysis system, financial management, and audits by the DHEW audit agency. In addition, special technical

assistance is available for specific problems. The total system is constantly reviewed and, as necessary, modified to assure that it is an effective tool for comparing intermediary and carrier performance with predetermined objectives and norms.

The result of these efforts is an ability to determine with reasonable promptness where problems exist so that corrective action can be taken. Appropriate staff then concentrate on these areas, working closely with specific intermediaries and carriers to resolve problems before they become serious.

Contract performance review

An important device for providing intermediaries and carriers with an independent review of their performance is the contract performance review. This activity was implemented in January 1967. Through June 30, 1968, onsite performance reviews had been made at over 90 intermediary and carrier claims processing centers.

The Bureau of Health Insurance review team spends from 3 to 5 days discussing operational problems with intermediary or carrier management as well as actually observing procedures, examining records, and interviewing appropriate personnel at all levels. Indepth study is made of personnel and management practices; claims processing; program integrity; application of reimbursement principles; professional relations; and beneficiary services.

A most important aspect of the performance review is the exit interview. At that time the team's findings are presented orally for consideration by the management of the intermediary or carrier. In this setting the Bureau of Health Insurance team and the contractor's management consult together concerning appropriate measures to improve any areas of operation which the review has revealed are in need of remedial action.

Subsequent to the review the team prepares a report including findings and recommendations for improvement which serves as a reference document for the intermediary and carrier in working to overcome any problems noted during the review. Since recommendations for improvement may often require extensive operational modifications and, consequently, considerable time for implementation, appropriate followups are made to determine any difficulties that the intermediary or carrier has in implementing such recommendations. These followup discussions are the responsibility of the Bureau of Health Insurance regional office staff who are able to offer any additional consultation in making agreed-upon changes.

The performance review activity affords the Bureau of Health Insurance the opportunity to provide each intermediary and carrier with the benefit of the problem-solving experience of other organizations also serving the health insurance program. By the same token, as a result of the individual reviews, ideas are generated for various modifications which will simplify operations, reduce costs, and provide better service. In furtherance of this objective, plans are being developed to publish findings and recommendations which would apply in general to intermediary and carrier operations and which would, in addition, generate ideas from intermediaries and carriers that could prove useful in overall health insurance administration.

Contractor operations analysis

Intermediaries and carriers submit several types of reports, both workload and financial, on a monthly or quarterly basis as appropriate. These reports, when analyzed together, measure the operations performed in terms of work units and the manpower and costs required in that performance. The monthly workload reports reflect not only the quantity of work being performed, but also the timeliness of performance and the complexity involved. Quantity is measured grossly in units received and cleared, whereas currency of performance is reflected in terms of workload backlogs and the quantity of cases pending over 30 days. The complexity of work performed is indicated through the breakdown of claims by type. For example, the breakout for Part A identifies bills submited by type of provider, i.e., inpatient hospital, outpatient hospital, extended care facility and home health agency. The breakout for Part B identifies claims assigned, claims not assigned, as well as hospital-based and group practice prepayment plan physician service claims. Also, complexity is measured by counts of cases which have to be returned for additional information or otherwise investigated before processing can be completed.

The basic objective of the monitoring system is to summarize the most pertinent data from various sources on an individual company basis and in terms of national averages or pars for comparison purposes. Also, other pertinent information gleaned from correspondence and personal contacts is included in the reports. Significant differences between individual company performance and national averages or pars are identified and referred to regional offices for further attention.

In addition to monitoring the information flowing into central office, performance areas are selected on a monthly or bimonthly basis for indepth analysis. In the course of a year, approximately eight topics will be covered by this close scrutiny. This work is completed largely by field personnel by means of onsite visits. In this way, activities which do not receive direct attention during the course of the regular review process are given a more intensive review.

These contract monitor reports are furnished to top management as a quick reference to determine the position of each intermediary and carrier with respect to the more significant yardsticks available, and are indicators of trouble spots. Under this system, the Bureau of Health Insurance can determine at a glance how an intermediary or carrier is progressing and what, if any, deficiencies are present. By means of this monitoring system, problems can be identified at early stages, and through the coordinated efforts of intermediaries, carriers, and the Bureau of Health Insurance staff, problem situations can be responded to more effectively and more rapidly.

Financial management

Major effort in fiscal 1968 regarding management of the financial aspects of the program was emphasized in two areas of contractor operations: first, improvement of fiscal policies designed to achieve maximum economy without adversely affecting program efficiency or impairing the attainment of program objectives and second, to assure

more complete review of intermediary and carrier operations for the purpose of maintaining better control over program administrative costs.

In the latter part of fiscal year 1968, policy guidelines were issued to intermediaries and carriers on the sharing of costs between the Medicare program and their regular business, when information from Medicare records is used in processing complementary insurance claims for Medicare beneficiaries. Generally, intermediaries and carriers obtain and use Medicare information in one of two ways; either they make copies of Medicare documents for association with the complementary claim, or they integrate their complementary insurance claims process with the Medicare claims process. The principles set forth in this policy require intermediaries and carriers to share the costs of any operation from which they derive some benefit either directly or indirectly, in connection with their own business. The refined methods of cost allocation resulting from implementation of this policy will produce a more equitable sharing of costs and thereby reduce program costs by about $2.5 million annually.

A significant fiscal policy change was developed specifically for the purpose of reducing operating costs within one of the most expensive operations in the Medicare program; that is, auditing providers. Based on prior audit requirements, the ongoing costs of auditing providers would have been approximately $28 million. By implementing the new policy, there should be significant reduction in the cost of provider audits so that the ongoing cost will be approximately $20 million—a savings of $8 million annually. Basically, these costs will be reduced by changing the requirements so that full scope audits will not be required in every instance and, where hospitals have demonstrated a history of good recordkeeping and accurate costing, audits will not be conducted on an annual basis.

During fiscal 1968, the Bureau of Health Insurance conducted 49 fiscal reviews of intermediaries and carriers. These fiscal reviews are onsite visits to the intermediaries or carriers for a period of 2 to 3 days during which time financial problems in such areas as audit exceptions, budget requirements, methods of cost allocation, and reporting practices are discussed in depth. Questions on fiscal policy are discussed in depth and more efficient ways of conducting operations from a financial point of view are explored.

A cost analysis report has been developed which includes several indexes for making a quantitative comparison of intermediary and carrier operations. These indexes include among others unit cost, ratio of administrative costs to benefits, and productivity. Those intermediaries and carriers which do not fall within an acceptable range from the norm are then identified and efforts are concentrated on these organizations to determine the reasons for the variations and to find ways of bringing them within acceptable limits.

Audit of intermediaries and carriers by DHEW audit agency

The DHEW Audit Agency is responsible for auditing the annual cost report submitted by each intermediary and carrier, which forms the basis for the final cost settlement. A copy of each proposed settlement, along with any remarks by the fiscal personnel or contract administrators of the Bureau of Health Insurance, is forwarded to the DHEW Audit Agency.

While the primary purpose of the audit is the review of allowability of administrative costs, the scope of the audits is not limited to financial considerations. It includes an examination of each intermediary and carrier operation to (1) verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations and procedures; (2) ascertain whether policies, plans, and procedures are adequate and being adhered to; (3) provide management with systematic appraisals of financial and administrative controls and information as to whether operations are carried out effectively, efficiently, and economically; and (4) to determine reliability of financial records and reports.

During the fiscal year, 98 audit reports were received from the DHEW Audit Agency and 55 closing agreements were processed. Considering only those audits which were completed during the year and closing agreements signed, intermediaries and carriers claimed $11,668,436. The auditors took exception to $234,491, SSA disallowed $147,443, and the total amount of settlement was $11,520,993. The total amount of settlement was $11,520,993. The total amount settled was 98.7 percent of the amount claimed. However, it should be noted that some of the claims not yet settled are those involving audit exceptions for substantial amounts of money. In subsequent periods, the amount of cost disallowed is expected to be about 2 percent of the total amount claimed.

C. REIMBURSEMENT POLICIES AND PROCEDURES

Reimbursement to participating providers, that is, hospitals, extended care facilities, and home health agencies, under both the hospital insurance and medical insurance programs, is required by law to be based on the "reasonable costs" of furnishing covered services to Medicare beneficiaries. Reimbursement under the medical insurance program for covered services which are furnished by physicians or others who render services on a charge basis, is required by law to be based on the "reasonable charges" for such services. Special adaptations of these charge provisions are applied to group practice prepayment plans who elect to have their services to members reimbursed on a reasonable cost basis.

Provider reimbursement [13]

In determining reimbursement for provider costs, all provider expenses directly or indirectly related to patient care costs are recognized, including depreciation, interest, educational costs, compensation of owners, an allowance in lieu of costs not otherwise reflected in the principles of reimbursement, and, for proprietary institutions, an allowance representing a reasonable return on equity capital.

Because the law requires that reimbursement to providers may not result in the Medicare program reimbursing costs attributable to care furnished to non-Medicare beneficiaries and, equally, that others do not bear any part of the costs of services rendered to Medicare beneficiaries, methods of apportionment of these separate costs must

[13] The principles of reimbursement for provider costs were developed in late 1965 and early 1966, on the basis of extensive discussions between the Social Security Administration and representatives of all segments of the health field, as well as other major health care insurers. They were first published in May 1966 under the title "Principles of Reimbursement for Provider Costs." They have since been incorporated in Federal regulations. See appendix B.

be used. In general, the apportionment is computed by taking the ratio between the charges for services rendered to Medicare beneficiaries and the charges for services rendered to the provider's total patient population and applying this ratio to the total operating costs of the provider which are attributable to patient care services. This is commonly called the RCC method (ratio of charges to costs), and, on occasion, the RCCAC method (ratio of charges to charges applied to costs).

At the outset of the program, two approved methods were established for cost apportionment, either of which may be used at the option of the provider. The departmental method applies the beneficiary's share of total charges, on a departmental basis, to total costs for the respective departments in the institution. The combination method reimburses the provider for routine services furnished Medicare beneficiaries on an average per diem basis but apportions the costs of ancillary services between Medicare and non-Medicare patients on the basis of the ratio between ancillary charges to Medicare patients and total ancillary charges. Temporary methods of cost apportionment for accounting periods ending before December 31, 1968, were permitted for providers who were unable to use the two approved methods and special methods have been developed for providers having an all-inclusive rate or no-charge structure.[14]

Since the actual costs of services cannot be determined until the end of the provider's accounting period, providers are paid currently on the basis of estimated costs. This is accomplished through interim payments, generally computed as a percentage of the charges billed, which are made to the provider at weekly or, sometimes, biweekly intervals. If the interim rate of payment has been carefully determined, the provider receives payment closely related to the rate of current billing and a close relationship should exist at the end of the year between the amount due the provider on the final cost settlement and the total amount of interim payments he has received over the accounting period. Preliminary indications for the first accounting period are that interim payment totals are less than final cost settlement amounts by about 5 percent.

In addition to interim payments, providers may request current financing payments. These payments are intended to finance the care being furnished to beneficiaries during their inpatient stay in the facility, even though billings have not yet been submitted to the intermediary on their behalf. They are computed so as to reflect each provider's cost experience in the program and are recomputed quarterly in order to consider the provider's most recent experience.

The availability of accelerated payments on account was continued in fiscal 1968 for providers who were able to demonstrate that their operating capital situation was being adversely affected temporarily, because of billing or payment delays. Rather than modify interim or current financing payments to cover a limited period of difficulty, the mechanism of accelerated payments has proven helpful. Because of improvements in billing and processing efficiency in fiscal 1968, payments under this provision were only two-thirds of the somewhat over $25 million paid to providers under this provision in fiscal 1967.

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[14] See pp. 53–54 for a discussion on all-inclusive rate and no-charge structure hospital.

A new method of interim reimbursement was established, beginning with January 1, 1968, which permitted interim payments to providers without regard to billings. This method is called periodic interim payment (PIP). Based on prior cost experience and estimates of anticipated patient use of facilities over the provider's accounting year, a schedule of equal payments is computed and paid, generally at weekly intervals, without regard to patient use of facilities during each payment period. The most significant advantage of PIP for providers is that it permits them to achieve improved management because of the assured receipt of fixed payments on a regular basis.

The acceptance of this new interim reimbursement method has been limited. As of June 30, 1968, only 123 hospitals had elected to be paid in this manner. Intermediaries are continuing to discuss this new method with their providers and, as the many advantages become better understood, an increasing number of hospitals are expected to adopt this procedure.

In an effort to assure that providers are fully familiar with the principles of reimbursement, the Administration has prepared and distributed a "Provider Reimbursement Manual." The manual defines the principles in considerable detail and illustrates their application to a variety of situations. It also contains detailed information on the preparation of annual cost reports upon which final cost settlements are based. In addition, new hospital cost forms were developed for distribution in fiscal 1969. These forms were designed to also accommodate the cost submittal requirements of the child health and medical assistance programs under titles V and XIX of the Social Security Act. The use of these common cost forms should reduce the amount of effort needed by providers to obtain reimbursement under all three health programs. Their use will also facilitate the common audit of provider records for all three programs which is currently being negotiated between the Social Security Administration and the Social and Rehabilitation Service.

All-inclusive rate or no-charge structure facilities

The general principles of reimbursement are not readily adaptable for use in institutions which do not have a charge structure or which use a fixed, all-inclusive per diem rate for services rendered to all patients. When hospitals do not charge for each service rendered, accumulated charges are not available as a basis for apportioning the costs of services between Medicare and non-Medicare patients.

A special study was undertaken to determine how the cost of covered services furnished Medicare beneficiaries should be determined in such hospitals. Many of these hospitals represent large public hospital systems including long-term psychiatric, tuberculosis, and chronic disease hospitals. Traditionally, such institutions have received an annual budget allocation within which to operate. While an accounting had to be made for the total allocation, no requirement existed for determining costs of services rendered to specific patients or classes of patients. Therefore, these hospitals did not maintain routinely the records or data necessary to permit a determination of Medicare's share of such costs.

As a result of this study, a number of temporary alternative methods were devised for apportioning costs of the all-inclusive rate and no-

charge structure hospitals to Medicare and non-Medicare patients. These temporary methods were made available initially for use in apportioning costs incurred during Medicare cost-reporting periods ending before January 1, 1969. Because many all-inclusive rate or no-charge structure institutions will need additional time to more fully develop their statistical data and accounting systems, the period in which the temporary alternative methods may be used has been extended to cost reporting periods ending before January 1, 1970.

In order to establish a permanent method of apportionment for the all-inclusive rate and no-charge structure hospitals, the Administration has conducted numerous onsite evaluations of the temporary methods implemented by these hospitals. Of the alternative temporary methods, the departmental statistical method appears to be the most reliable for use in the all-inclusive rate and no-charge structure hospital. Under this method Medicare's share of routine service costs is determined by computing, for either type of hospital, an average per diem cost of routine services and multiplying this figure by total days of care to Medicare patients or, for all-inclusive rate hospitals, applying the ratio of Medicare inpatient charges and total impatient charges to the hospital's total inpatient costs for routine care. The Medicare portion of ancillary service costs, for both types of hospital, is determined on the basis of the ratio between utilization statistics for Medicare patients and for all patients. This method offers a more accurate basis than the other temporary methods for apportioning costs, through the use of weighted statistics.

Differential levels of care in extended care facilities

Another special payment situation occurs when extended care facilities assess differential charges for routine services based on estimated variations in the level of care. Under Medicare, care in an extended care facility was designed to represent the next appropriate step after the intensive care furnished in a hospital. It was intended to make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients. The program concept of an extended care facility is that it is an institution, or a "distinct part" of an institution, providing to all inpatients a more or less uniform level of care, defined as extended care services.

Because Medicare reimbursement is designed to approximate as nearly as possible the actual cost of providing services to Medicare beneficiaries, extended care facilities have been permitted to apportion routine care under Medicare for an interim period, on the basis of their customary charging practices which reflect estimated variations in the levels of routine care furnished to different patients. During this interim period, however, providers are expected to make whatever adjustments and preparations are necessary in their methods of operations and in their charging practices to conform to the program concept of an extended care facility, that is, a facility, or distinct part of a facility, providing more or less uniform care to all of its patients. Upon the expiration of the interim period, the Medicare program will consider that all patients in an extended care facility are receiving extended care level services and that any differential charges for rou-

tine services in the extended care facility will be acceptable for program purposes only where they are based on differences in accommodations.

There is a provision in the law that a distinct part of an institution may be certified as an extended care facility. Under this provision, the standards of care required to participate in the program as an extended care facility would apply only to the extended care facility part. Thus, in a nursing home or home for the aged, the level of care provided in the noncertified part could be much lower than in the distinct part certified as an extended care facility. Those patients who do not require the same level of nursing and other services provided for extended care patients may be placed in that area of the institution which is not providing extended care services, and under these circumstances the Medicare reimbursement procedures do provide for the recognition of the higher costs of the part certified as the extended care facility.

Provider cost analysis program

The program is charged with more than just the responsibility for payment to providers on the basis of reasonable cost for services rendered to Medicare beneficiaries. It is also committed to a continuing evaluation of the effect of Medicare reimbursement on the financial condition of providers participating in the program. In order to evaluate the reasonableness of cost, to provide operating data as an aid in evaluating the principles of reimbursement, and to develop needed cost and financial data, a program of cost and financial analysis has been undertaken which will initially be applied to participating hospitals. This program is designed essentially to facilitate program management but provides sufficient detail for indepth analysis of indicated problem areas. With such information it will be possible to determine and evaluate the reasonable costs incurred by an individual provider or group of providers, and permit a comparison of their cost and financial experience with similar hospitals or groups of hospitals on a regional or national basis. Cost and related charge data as well as significant operating and financial information will be summarized and analyzed.

Reimbursement of physicians and suppliers

The medical insurance program was designed primarily to reimburse physicians' fees and other medical services ordinarily rendered on a charge basis. To assure appropriate limits to the risks underwritten by the Medicare program, the law requires that these services be reimbursed on the basis of "reasonable charges."

The law requires that in determining reasonable charges, carriers should take into account the customary charges of physicians and other suppliers of medical services and the prevailing charges in the locality for similar services. The law also specifies that the reasonable charge for a service may not exceed the charge applicable for a similar service and under comparable circumstances to the carrier's own policyholders and subscribers. The reasonable charge, therefore, is a charge for a service which in the absence of unusual circumstances or medical complications is the lowest of the following: (1) the actual charge of the physician or other person rendering the service, (2) the

charge the physician or other person customarily makes for similar services, (3) the prevailing charges in the locality for similar services, or (4) the charge upon which the carrier bases payment to its own subscribers for similar services under comparable circumstances.

Under Medicare, the customary charge for a service is intended to be the charge the physician or supplier would ordinarily make for a comparable service to his patients or customers in general. Prevailing charges are those charges which fall within the range of charges most frequently and widely made in a locality for similar services. In applying the customary and prevailing criteria the carriers, of course, take into account situations where unusual circumstances or medical complications warrant a higher charge in a particular case.

Intensive efforts were made during the year to assure proper reimbursement for the services of provider-based physicians and teaching physicians. These two areas of reimbursement are among the more complex to administer.

For provider-based physicians the regulations, by and large, limit Medicare reimbursement to the compensation they receive from a provider if they are on a salaried or similar compensation type basis. The difficulty experienced throughout the first year of operation with respect to split billing required under Medicare for radiologists' and pathologists' services was, to a considerable extent, reduced by the administrative simplification in the 1967 amendments to the Social Security Act which permitted billing by the hospital on a consolidated basis for inpatient radiology and pathology services. However, the Department is increasingly concerned with a significant trend toward changes in the pattern of arrangements between provider-based physicians and providers, particularly in the case of radiologists, many of whose arrangements with hospitals have been modified so that the hospitals and physicians may bill patients separately for their respective services. When independent billing arrangements replace a prior compensation arrangement, the objective in determining reasonable charges for the physician services is to assure that there is no unreasonable increase in the physician's patient income under the new arrangement compared to patient income for the same services under the prior arrangement. A number of intermediaries and carriers have had difficulty in securing conformity with this objective and further efforts in this area are particularly essential.

With regard to attending physicians who supervise interns and residents in a teaching setting, the Medicare regulations and policies recognize a charge by the attending physician in this setting only if he personally renders a medical service required for the beneficiary's medical care. The regulations for determining reasonable charges in a teaching setting specify that a charge should be recognized under the medical insurance program for the services of a physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character as the services he renders to his other paying patients, in terms of the medical responsibilities for the patient's care that he assumes and fulfills. Guidelines have been issued which specifically outline the conditions under which the program can recognize a physician as an attending physician eligible for reimbursement for his patient services. The implementation of these

guidelines has required the continuing attention of intermediaries and carriers because of the varied situations that are presented and differences in interpretation by the medical profession and providers.

During the past year members of the Department conducted comprehensive training programs, participated at meetings of professional organizations in the health insurance field, and held meetings with medical staff of hospitals and those on the faculty of medical schools who are engaged in the teaching of interns and residents, in order to clarify the regulations in respect to reimbursement for provider-based physicians and teaching physicians, and to emphasize the goals of the Medicare program so that a common understanding will be achieved. Also, the Administration has intensified its studies and reviews of intermediary and carrier performance in implementing the regulations and guidelines concerning reimbursement in these areas and is accelerating this review program with the objective of assuring that they are achieving the intent of these regulations and have a proper statistical basis on which to take appropriate action in preventing either improper charges or unwarranted increases in charges. During these reviews with both intermediaries and carriers, special attention is paid to staff training and instructional needs to assure that the regulations and guidelines are correctly implemented.

Reimbursement of group practice prepayment plans

Most services covered by the medical insurance program are rendered on a fee-for-service basis, and reimbursement is based on the reasonable charges for the specific services furnished. However, services furnished under group practice prepayment plans are normally rendered in return for premium payments, which are not based on any individual member's actual or expected use of plan services, but on the actual or expected use of plan services by all members. In recognition of the need for special adaptation of the Medicare payment procedures for services rendered by group practice prepayment plans, the law provides that an organization which furnishes medical and other health services (or arranges for their availability) on a prepayment basis, may elect to be paid 80 percent of the reasonable costs for such services in lieu of reasonable charges. Plans which elect this reimbusement option deal directly with the Social Security Administration rather than through carriers.

During the past year, the Administration has dealt directly with 23 plans on such a reasonable cost basis.[15] These plans have a total membership of approximately 3 million, of which 260,000 are Medicare enrollees. A total of $22.1 million in Medicare payments has been paid to these plans during the period July 1, 1967, through June 30, 1968.

Interim monthly payments are made to these plans for medical insurance services rendered to Medicare beneficiaries. These payments are based on cost and utilization data from the preceding year and have been adjusted to reflect the current year enrollment, utilization, and operating costs. The total amount of these payments is adjusted at the end of the accounting year so that the total payments equal the cost of covered services to Medicare beneficiaries minus an allowance for applicable deductibles and coinsurance amounts.

[15] A list of these plans is given in app. B.

Many plans have felt that, under this method of reimbursement, Medicare members do not share in the plan's total costs to the same extent as other plan members. In effect, non-Medicare members of the plan are required to subsidize the Medicare member for those amounts in excess of the budgeted costs of providing medical care which the plan requires to operate effectively. A new method of reimbursement was introduced during fiscal 1968 whereby group practice prepayment plans may be reimbursed reasonable charges on a nonbill basis. Reimbursement under this method will result in Medicare members sharing in the plan's total costs to the same extent as other plan members. Since payments to the plan will be made on other than an individual bill basis they will subject to a retroactive adjustment after a cost finding is made at the end of each accounting period.

Incentive reimbursement experimentation

The Social Security Amendments of 1967 authorized the Secretary of Health, Education, and Welfare, under Medicare, medicaid, and the maternal and child health programs, to experiment with alternative methods of reimbursement to institutions and for physicians' services.[16] The provision reflects congressional interest in developing reimbursement methods which, at the same time they support high quality services, will also provide incentives to efficiency and economy and lead to lower overall program costs than the reimbursement methods now provided for under the law. The principal features of the new provision are as follows:

1. For purposes of the experiments, the generally applicable reasonable cost and reasonable charge provisions may be waived. Any additional cost to the Medicare program resulting from the experiments will be met from the appropriate social security trust funds. Under the medicaid or maternal and child health programs the Secretary is authorized to reimburse States for additional costs resulting from the experiments.

2. The projects will apply experimental methods of reimbursement or payment to demonstrate the effect of the methods on efficiency, economy, and the quality of care. Before selecting an experiment, the Department must obtain the advice and recommendations of specialists who are competent to evaluate it as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct it, and its relationship to other similar experiments already completed or in process.

3. Participation in the experiments by institutions, organizations, and physicians will be voluntary.

Implementation of the experimentation program

The Department of Health, Education, and Welfare has placed a high priority on the development of suitable experiments, and the Social Security Administration, the Social and Rehabilitation Service, Public Health Service, and other components of the Department have met with other public and private third-party payers, professional and provider associations and health care institutions and organizations to seek and try out the best ideas for methods of reimbursement that may promote lower health care costs.

[16] Sec. 402 of the 1967 amendments to the Social Security Act. See app. A.

In order to encourage and facilitate the widest possible participation by all parties involved in the delivery and financing of health care services, the incentive reimbursement program was given wide publicity. As early as November and December 1967, meetings were held with individuals and with representatives of groups interested in participating in reimbursement experiments. Following enactment of Public Law 90–248 on January 2, 1968, contacts with potential experimenters were expanded to solicit their early submittal of proposals. In the spring of 1968, guidelines setting forth and explaining the objectives to be sought in incentive reimbursement experiments, the criteria to be used in evaluating proposals to experiment, and priorities to be used in selecting experiments for implementation, the standards for conducting experiments, and the procedures for submission, review, and selection of proposals were widely distributed to organizations and individuals whose interest in the experimental program was known or anticipated. Face-to-face meetings were also held with organizations possessing the capacity to formulate and sponsor experiments or do related research—provider groups, public and private third-party payers, university groups, and private research organizations.

At the time of this report, over 500 individuals, associations, and organizations have written to the Department requesting copies or additional copies of the guidelines. In addition to proposals, ideas, and offers expressed at meetings, the Administration has received written inquiries concerning its views with respect to specific ideas for possible development as experiments, general offers to participate in experiments which may be developed, and about 50 more or less specific proposals to experiment.

The administrative process that has been followed is outlined below:

1. Review and screening of proposals by the operating agency or agencies and through a departmental coordinating committee established to coordinate activities related to the program.
2. Submission of experiments that are being considered for implementation to the Advisory Panel on Incentive Reimbursement Experimentation appointed in May 1968 to advise the Secretary on reimbursement experimentation.[17]
3. Implementation and evaluation of the results of approved experiments by the appropriate Government and private third-party payers, providers of services, and research organizations.

Close liaison has been maintained between the Advisory Panel and the Health Insurance Benefits Advisory Council so that the views and concerns of the Council can be taken into account by the Advisory Panel and to facilitate HIBAC review of specific proposals where such review is requested by the Advisory Panel or by the Department.

The Advisory Panel held its first meeting on June 22, 1968, and met again on September 27 and 28. The first meeting of the panel was primarily an orientation meeting, although a number of résumés of proposals were presented for initial review by the panel. To facilitate its work, the panel decided to operate by establishing ad hoc subcommittees for the purpose of evaluating individual proposals prior to consideration by the panel as a whole. A separate subcommittee was also established to set forth the kinds of experimental hypotheses and

[17] A list of members of the Advisory Panel appears in app. B.

demonstrations to be undertaken, including identification of the research needs of the program and identification of likely areas where experiments may be engaged in or developed. At its September meeting, the panel concentrated on the research needs of the program and discussion of those proposals that had previously been reviewed by subcommittees of the panel.

Four carefully designed, well-laid-out experimental proposals have received approval for their full development and are close to final approval.

The first of these is to employ the Hospital Cost Analysis Service, Inc., an existing Maryland nonprofit organization, armed at present with hospital cost-finding authority for the Blue Cross and State programs, and to assign to this agency consultative and educational responsibilities. The agency's work would proceed in four steps: first, to review the costs of all of the participating voluntary hospitals in Maryland and to compare them with each other and with hospitals throughout the United States; second, to determine which hospitals have high costs because of managerial inefficiency or poor accounting practices; third, to suggest ways for high-cost hospitals to reduce their costs; and, fourth, to establish maximums third parties will pay, maximums which are realistic if the hospitals follow good administrative practice.

The second plan, sponsored by the Associated Hospital Service (Blue Cross) and Hospital Association of Greater New York, is to establish an inpatient per diem target rate for Medicare and Blue Cross reimbursement to each hospital participating in the experiment. The target would be proposed by the hospital and approved by the Blue Cross plan, with incentive payments made for achieving a lower rate than the target and penalties for exceeding the target rate.

The third plan is to establish departmental target reimbursement rates for Connecticut's hospitals. Rate approval boards consisting of hospital administrators, controllers, directors of nursing, physicians, and hospital trustees would do the rate setting. This plan would emphasize labor per unit of measurable output—pound of laundry, cost per meal, et cetera, and a system of reimbursement incentives would be based on actual performance compared with the target.

The fourth experiment is to allow the Health Insurance Plan of Greater New York to pay hospitals providing services to members of the plan on a negotiated capitation basis, so that the hospitals would receive no less reimbursement if they helped reduce the amount of in-hospital services provided, and no more reimbursement if they kept the patients in the hospital longer. Final cost estimates for these four proposals will have to await further development of the plans in accordance with recommendations made.

Other proposals and studies

Review by components of the Department has resulted in 10 proposals being formally referred to the National Center for Health Services Research and Development for their consideration. Some denial letters have been sent to organizations and individuals whose submittals did not meet the requirements of the incentive reimbursement guidelines. Other proposals are in various stages of review within the Department.

D. ACHIEVING MAXIMUM PARTICIPATION BY QUALIFIED PROVIDERS

By January 1967, the great bulk of certification activity had taken place.[18] During this initial phase of the certification process the most important consideration was to bring into the program as many providers as possible, so long as they met the health and safety requirements of the program and the requirements of title VI of the Civil Rights Act. The great majority of hospitals and a large number of extended care facilities and home health agencies were able to fully meet the conditions of participation. A number were certified conditionally, with the understanding that identified deficiencies would be promptly corrected. Approximately 600 hospitals were certified under the "special access" provision of the regulations, which permitted certification where a failure to certify would have deprived beneficiaries of access to local health facilities from which they had regularly received health services. In no instance, of course, could a hospital be certified under this provision where the patient's health and safety might be adversely affected by receiving care from such a facility.

During Medicare's second year, the main emphasis of certification activity has been focused on upgrading those facilities which did not fully meet the program's conditions of participation. Significant improvement has resulted from this more intensive State agency activity which has involved greatly expanded consultation with providers to correct deficiencies. Some facilities which could not overcome deficiencies or were unable to continue to meet the requirements for participation voluntarily withdrew from the program, while others had their agreements terminated by the Secretary. These activities are discussed in greater detail in the following sections.

In addition, the 1967 amendments provided coverage for additional outpatient physical therapy services and for portable X-ray services. Considerable effort was involved during fiscal 1968 in certifying potential providers of these new services.

Title VI of the Civil Rights Act

In addition to meeting the quality standards established under the health insurance program, hospitals, extended care facilities, and home health agencies wishing to participate in the Medicare program must be in compliance with title VI of the Civil Rights Act of 1964. Under this act, a participating provider may not engage in discriminatory practices on the basis of race, color, or national origin.

In the first annual report on Medicare, it was reported that every effort had been made by the Department to secure voluntary compliance of institutions with the civil rights requirement. These efforts to secure voluntary compliance are continuing, and it is estimated that at the end of fiscal 1968 there were less than 30 hospitals which could meet Medicare's health and safety standards but are not participating presumably because of failure to comply with title VI requirements.

Emergency hospital services

In enacting the original Medicare legislation, Congress recognized that there might be situations in which beneficiaries would require

[18] State agencies, under agreements with the Secretary of Health, Education, and Welfare, survey potential participating facilities and make recommendations for certification to the Secretary. See p. 35.

emergency hospital services and that this might sometimes result in their being taken to an institution which was not participating in the program. In such situations, it was felt that where the nonparticipating hospital met certain requirements assuring the health and safety of their emergency-care patients, the program should pay for the services. It was intended, however, that payment should only be made for the duration of the need for emergency care and only where, taking into account the availability of any nearby participating hospitals, the nonparticipating facility was, in fact, the most accessible hospital able to furnish the necessary emergency care.

Prior to fiscal year 1968, approximately 260 hospitals had been submitting claims under these emergency provisions. At the end of fiscal year 1968, more than 70 of these facilities had become participating providers. Since January 1968, 15 hospitals, with a total of 1,626 beds, that have been submitting close to 20 percent of the national total of emergency claims, are now fully participating in the program. For example, a hospital in Texas that had been submitting 43 percent of that State's emergency claims, is now a participating provider. In Louisiana five hospitals accounting for about 30 percent of that State's emergency claims have become participating providers, as well as six hospitals in Georgia previously submitting 23 percent of that State's emergency claims.

There are approximately 30 of the remaining hospitals which meet the health and safety requirements of the program and whose failure to become participating providers is based upon problems in complying with the civil rights requirements. The Department's Office of Civil Rights is working closely with hospital associations and professional organizations to assist these facilities in meeting the civil rights requirements. As a result of these efforts, several more hospitals, especially in Mississippi and Alabama (where most of the 30 hospitals are located), are expected to become fully participating providers during fiscal year 1969.

In order to assure that emergency care is reimbursable only when the nonparticipating hospital is, in fact, the most accessible hospital and that the services rendered are truly of an emergency nature, the Department has recently promulgated additional regulations providing for more specific documentation as to both the medical need for the emergency care and whether the most accessible hospital available is being used.

Payment for emergency services can only be made if the claim for payment is accompanied by sufficient information to show that the hospital was the most accessible hospital available equipped to handle the emergency and by a supporting statement from a physician certifying the emergency nature of the hospitalization. The Public Health Service has responsibility for determining whether an emergency claim meets the medical necessity requirements of the regulations. In determining whether the hospital admission was of an emergency nature, review physicians in the regional offices of the Service evaluate the attending physician's statements, and, in most instances, the hospital records.

It is anticipated that the regulations along with the increasing number of nonparticipating hospitals that are being brought into the

program, will result in a substantial decline in the number of emergency claims.

Certification of hospitals

In the fiscal year ending June 30, 1968, a total of 6,865 general, psychiatric and tuberculosis hospitals had been certified to participate in the health insurance program. Of the total certified general hospitals, 600 had been certified under the "special access" provisions.

The State agencies have reported that those hospitals which received special access certification have, in general, made significant progress toward correction of their original deficiencies. The nationwide shortage of registered nurses, however, is especially acute in those rural and isolated areas where most access facilities are located and has remained the single most significant obstacle for these hospitals to overcome, despite their continuing recruitment efforts.

The access hospitals have, however, made measurable strides in such areas as correction of physical plant deficiencies (e.g., installation of sprinkler, emergency gas, water and power systems, etc.), obtaining the services of pathologists, qualified dietitians, medical records librarians, and the purchase of new equipment for operating and recovery rooms, such as cardiac monitors and defibrillators.

Terminations

During fiscal year ending June 30, 1968, 32 agreements with hospitals were terminated either by the voluntary request of the provider or by the Secretary. Eleven were terminated for failure to comply with the statute and regulations. The primary reason for termination in 10 of the 11 hospitals was failure of the facilities to meet the nursing requirements of section 1861(e)(5) of the law. The other hospital was terminated for failure to comply with the health and safety requirements as set forth in the Federal regulations.

Twenty-one hospitals, which consisted of 749 beds, requested and were approved for voluntary withdrawal from the program during this same period. Twelve of these voluntary terminations resulted from the inability of the facilities to continue to meet the conditions of participation and the realization by the hospitals that termination by the Secretary would result from continued noncompliance. One hospital withdrew from the program when it discontinued its operation. The remaining eight hospitals requested termination of their agreements due to the fact that they had had few, if any, Medicare admissions during the previous fiscal year.[19]

Extended care facilities

As of July 1968, there were 4,702 extended care facilities participating in the Medicare program. A basic problem continued to be the availability of extended care services in some locations. Data on the distribution of certified facilities relative to population density indicate wide variations throughout the country. Where there appear to be shortages, plans are underway to explore with appropriate agencies, in and out of the Government and at both Federal and State levels, what can be done to encourage the establishment and Medicare participation of additional extended care facilities.

[19] Additional involuntary terminations processed since June 1, 1968: Hospitals, 16; extended care facilities, 15; total of 31. Additional voluntary terminations processed since June 1, 1968: Hospitals, 16; extended care facilities, 143; home health agencies, 23.

The ongoing resurveys of certified facilities indicate substantial improvements in many aspects of extended care services. For example, at the beginning of extended care coverage in January 1967, there were over 300 facilities which had been given conditional certifications, rather than full certifications, because of their inability to obtain qualified charge-nurses for each tour of duty. As of July 1968, there were only 53 facilities which had not yet corrected this deficiency. Moreover, as the cycle of periodic resurveys became operative, State agencies made more thorough inspections and offered more effective consultation, with the result that a substantial number of other deficiencies were disclosed and corrected.

The Social Security Administration and the Social and Rehabilitation Service are jointly engaged in studying the interrelationships of the title XVIII coverage of extended care services and title XIX benefits for other levels of nursing home care, so that appropriate consistency in health care standards and their implementation can be achieved with respect to the skilled nursing facilities covered by both programs.

The proliferation of "distinct part" extended care facilities is a matter which has caused some concern. Complex reimbursement and other administrative problems are sometimes involved where part of an institution is certified as an extended care facility while the remainder is left outside the Medicare program. To remedy this, new rules on establishment of "distinct parts" are being considered to allow for partial certification of an institution only where there is a genuine difference in levels of care based on medical needs of the patients, and not artificial breakdowns established principally to secure reimbursement advantages.

Utilization review

The conditions of participation for hospitals and extended care facilities require that each facility establish a utilization review committee, consisting of at least two physicians, to review all long-stay cases and to undertake sample reviews of admissions and professional services rendered. The utilization review mechanism is widely recognized as a method which can significantly contribute to the assurance of quality care through the more effective utilization of institutional facilities. However, utilization review remains a new and complex concept to many providers, particularly to extended care facilities, few of whom have organized medical staffs.

During the first operating year of Medicare, the Social Security Administration issued instructions to State agencies and fiscal intermediaries outlining their respective roles in assessing the effectiveness of utilization review activities by participating providers. In fiscal 1968, the Social Security Administration took additional steps to assure increased emphasis on utilization review in State agency and intermediary contacts with providers. Instructions have been issued to State agencies telling them to look beyond written utilization review plans to the operational aspects of committee functioning, within the framework of the established role for the State agency, and to give increased emphasis to assuring that committees are performing sample reviews of admissions and services rendered. The regional offices of the Bureau

of Health Insurance have initiated meetings of representatives of the State agencies and fiscal intermediaries, to encourage a mutual exchange of ideas and information, and to provide both groups with the opportunity to discuss their complementary roles in the light of specific cases. In addition, meetings have been held to train regional office personnel in current principles and policies regarding utilization review. On a national basis, the Social Security Administration has worked closely with the Blue Cross Association and other intermediaries to assure coordination of instructions and operating practices between the State agencies and the intermediaries.

Home health agencies

A great variety of professional and community organizations have participated with the involved governmental agencies to promote the availability and usage of home health services. The fact that some areas are not served at all and others are served only sparsely by home health agencies indicates that these efforts may not have been altogether successful in establishing this relatively new type of health care as a readily available resource when such services are needed in the health care of Medicare patients.

The Bureau of Health Insurance and the Public Health Service have investigated and discussed this situation with informed sources in a number of localities throughout the country. The facts usually disclosed are that there is a widespread public unfamiliarity with the concept of home health care as a professional level of health care.

A special study is being made of a limited number of communities in which the availability and usage of home health services relative to the over-age-65 population is markedly low. Detailed statistical and background information will be obtained concerning these communities, to determine whether the lack of availability or usage reflects an unmet need for home health services or whether the apparent shortage is due to the availability of other health facilities and to ingrained local customs and practices oriented toward the use of such other facilities. Although even in such areas it might be well to press for the greater usage of home health services, initial efforts will be concentrated in those communities where there is a public demand for such services which is unsatisfied because of lack or funds or personnel, or where a greater degree of local initiative is required to establish home health agencies.

Although, after 2 years of Medicare, an adequate availability of home health services remains the major problem in implementing the home health benefits provision, the program is giving increasing attention to improving the quality of services rendered by existing home health agencies and seeing that they are rendered at reasonable cost. To this end, survey and reimbursement guides are being revised to stress appropriate analysis by State agencies and intermediaries of the type and extent of care being rendered; that is, the degree to which physicians' instructions are being observed as to treatments given, frequency of visits, and similar elements of care.

Independent laboratories

By July 31, 1967, the initial certification of independent laboratories was virtually completed. Of the approximately 2,700 laboratories

which had originally submitted requests for approval, 2,566 had been approved as of that date; and about 150 had been denied approval to have one or more of their services reimbursed under the Medicare program. Of the denials, 21 have since requested reconsideration. Seven of these denials were reversed and in the remainder the denial was affirmed.

Following completion of initial certification activity, the State agencies, the Social Security Administration, and the Public Health Service began addressing themselves to the issues for continuing the eligibility of independent laboratories, especially those laboratories whose directors did not have the basic education and/or experience requirements necessary to qualify them as directors under the regulations. The most urgent issue relating to these individuals was the immediate need to qualify them as directors through the use of an examination sponsored by the Public Health Service, because approval of 461 laboratories beyond July 31, 1967, in whole or in part, depended solely upon the laboratory director taking and passing the written examination. The initial examination was given June 1–2, 1967. Make-up examinations were given late in June and again in July to assure that every individual who had expressed an intent to take the examination was not disadvantaged because of illness or other unavoidable absence.

As a result of experience gained and comments received from interested parties in the latest part of the certification activities, modification of certain of the regulations, originally published on December 16, 1966, was found to be desirable. Changes were jointly developed by SSA and the PHS and were incorporated into revised regulations published on January 13, 1968. These changes took into account comments and complaints received prior to hearings by the Committee on Ways and Means, as well as testimony presented to the committee. Among the more important changes were:

1. Liberalization in certain of the requirements, as well as limitation of the requirements to those tests laboratories perform for Medicare beneficiaries only.
2. Deferral of the proficiency testing requirements until July 31, 1968.
3. With respect to the June 30, 1971, expiration date for temporary qualification of certain personnel, criteria were established permitting individuals who qualified before 1971 to continue to qualify after June 30, 1971, on a permanent basis.

The immediate results of these modifications were that no laboratories were adversely affected by the regulations that nondoctoral directed laboratories successfully participate in a proficiency testing program by July 31, 1968. This was due, for the most part, to the fact that States having laboratories with nondoctoral directed laboratories were, by that later date, either already operating, or had recently approved, acceptable proficiency testing programs. In April 1968, each State was asked to report on the status of its proficiency testing program as it would be by July 31, 1968, and plans contemplated for 1968–69. Reports received indicated that six States would not have a Medicare required proficiency testing program in effect. This, however, did not pose any problem inasmuch as there were no laboratories approved in these States for whom participation in a proficiency test-

ing program was mandatory. The status reports reflect that full proficiency testing programs are operative in all the remaining States and that the programs cover all the specialties in which laboratories desiring participation in the program perform tests.

In modifying the regulations which allowed temporarily approved laboratories to remain in the program on a permanent basis after June 30, 1971, a provision was also made that, in addition to performing satisfactorily in a proficiency testing program, such laboratories must take part in a performance evaluation program. This evaluation program will place great reliance upon three main elements: (1) qualifications of personnel; (2) proper maintenance of records, equipment, facilities; and (3) effective quality control system.

Evaluation of these three critical elements, along with proficiency testing results, should determine whether a clinical laboratory is providing safe and dependable laboratory services. Recently revised laboratory survey forms will facilitate the gathering of such performance evaluation data. In addition, surveyors conducting surveys for Medicare must possess, as a minimum, a baccalaureate degree with a reliable laboratory science major and at least 3 years of broad experience in a clinical laboratory setting. By July 1, 1968, most State agencies had reported that qualified surveyors were on the State agency's staff or would be very shortly. At the time this report was prepared all State agencies had on their staff, either full time or as consultants, individuals with the necessary qualifications.

Outpatient physical therapy

Under the 1967 amendments to the Social Security Act, coverage of outpatient physical therapy services under the medical insurance plan was extended, effective July 1, 1968, to include such services furnished by providers of services, including clinics, rehabilitation agencies, or public health agencies. There are a total of 55 newly certified providers—that is, rehabilitation agencies, clinics and public health agencies—whose outpatient physical therapy services were reimbursable as of July 1, 1968.

In spite of the small number of rehabilitation agencies, clinics, and public health agencies certified as additional providers of outpatient physical therapy services, there are no signs of inadequate availability of such services because of absence of these new types of providers. This, quite likely, is because the over 13,000 participating hospitals, extended care facilities and home health agencies were deemed qualified, without any additional certifications, to provide covered outpatient physical therapy services. However, HHA's which wish to furnish such services on the premises of the agency must meet additional conditions of participation related to physical environment.

Certification of suppliers of portable X-ray services

The proposed regulations embodying the requirements which must be met by suppliers of portable X-ray services as conditions for coverage of their services were published on July 16, 1968. It was necessary, however, to identify and initially certify all qualified suppliers of such services without waiting for publication of proposed regulations since coverage of portable X-ray services became effective January 1, 1968. Therefore, an interim reimbursement procedure was instituted effective January 1, 1968, which permitted payment for covered

services rendered by apparently qualified suppliers. State agencies were instructed to make preliminary investigation of known suppliers to ascertain if any were known to be operating with significant deficiencies with respect to equipment, personnel operating the equipment, or method of operation. The State agencies, with assistance from carriers, identified and initially certified 140 suppliers of portable X-ray services. Of this total, approximately 30 are concentrated in California, which has the greatest number of owner-operators.

Following the publication of the proposed regulations, comments were received from the American College of Radiology, the New York State health agencies, the California Association of Portable Radiologic Technologists, and others. On the basis of the comments received and Administration review of the proposed regulations, a number of changes are being considered. The principal change provides for a "grandfather" clause which will enable operators to qualify by the substitution of training and experience for formal education requirements.[20]

Reviews of State agency performance

Two periodic review mechanisms have been developed to monitor State agency performance and identify areas in which improvements can be achieved.

Program review

Program reviews, carried out by personnel of the Bureau of Health Insurance and the Public Health Service, are designed to determine the effectiveness of the certification guidelines and the conditions of participation. Through June 30, 1968, 29 States had been visited by the review teams, and other States are being visited on a continuing basis. To gain firsthand knowledge of State problems in surveying and providing consultation to providers, and as a means of achieving a more complete evaluation of State agency survey activity, the program review teams have recently undertaken onsite surveys of a sampling of providers of service in conjunction with the program review visits. The surveys have proved to be an effective mechanism in identifying areas of weakness in survey and evaluation activities, where increased training emphasis of State surveys is necessary. These program reviews have also identified areas where further interpretation and clarification of the Federal regulations are necessary.

Comprehensive administrative review

Comprehensive administrative reviews of State agency administration of the provider certification process are carried out by Bureau of Health Insurance regional and central office staff members, usually with additional representation by Public Health Service regional staff. These are reviews in such areas as management of workload organization, personnel management, training, and financial management, as distinguished from the program reviews which are oriented toward the quality, consistency, and effectiveness of program execution.

The reviews of State agency staffing and organizational patterns identified the need for revision of a number of State plans and budgets to accommodate the financing of positions occupied by employees

[20] The regulations, including this change, were published in the Federal Register on Jan. 10, 1969.

who engage in multiprogram activities in States where employees wholly supported by health insurance funds perform services in other programs (usually State licensure) as well as Medicare. In most of the States in which this was observed, corrective action has already been taken by instituting acceptable time reporting systems or by better defining program duties.

The reviews also brought out various organizational problems involving lines of supervision, and inadequate emphasis on title XVIII objectives and priorities. This is an area in which there is a need for extensive further activity to evaluate State agency operations and to recommend methods for improving efficiency.

E. PROGRAM COST CONTROLS AND UTILIZATION SAFEGUARDS

When Congress designed the benefit structure for financing the Medicare program, it was anticipated that the costs of health care services would increase. The assumptions as to such increases were developed on the basis of past trends in health care prices. The financing for both the hospital insurance and the supplementary medical insurance programs thus allowed for an increase in the costs of hospital care and physician services on the basis of both previous experience and predicted trends.

During the course of Medicare's first year, however, it became increasingly apparent that the costs of hospital care were rising at a more rapid rate than had been anticipated in the actuarial assumptions which served as a basis for financing the hospital insurance program. As the same time, physician fees also rose somewhat more than had been anticipated in the actuarial assumptions which served as a basis for financing the supplementary medical insurance program (and this factor was recognized in determining the premium rate applicable for April 1968 through June 1969).

In Medicare's second year, both hospital costs and physician fees increased at about the same rates as had been assumed in the revised actuarial estimates which were made in 1967.

Increases in prices of health care services are not only the concern of Medicare and other insurers of health care services but, equally, it is the concern of every citizen, affecting, as it does, not only what he pays directly for health care but also what he pays in the form of constantly increasing insurance premiums.

In its first 2 years, Medicare paid almost $8.3 billion for health care services. This is approximately 45 percent of the total amount of benefits paid in that same period by all other health insurers in the Nation. By no means all of the Medicare disbursements were new income; much of them replaced other insurance. Clearly, however, the program had a substantial fiscal impact on the health community and carried with it the risk of inducing some price increase, especially when the economic sector affected was already operating close to its manpower and facility limits. It has been essential, therefore, that Medicare review increases in costs or charges to assure itself, as well as the public whose funds finance the program, that any such increases are responses, not just to the availability of additional funds, but also to the action of factors which the community as a whole would accept as establishing a justifiable basis for increases in the prices of products and services.

Apart from taking steps to assure that increases in costs and charges are warranted, there is another dimension of program costs which requires constant review and appropriate controls. This is the area of unnecessary or excessive utilization of covered services. Under the hospital insurance program, one of the most obvious examples of this is unnecessary occupancy of expensive inpatient facilities, when health services at that level of care are not required. An admission to a hospital for services which could be given on an outpatient basis, with equal medical effectiveness, is a particularly striking example of such a situation. A Friday admission to a hospital whose laboratory is closed on weekends, when the initial purpose of the admission is to secure diagnostic services, is another obvious situation in which costs are inappropriately generated. Extended stays in a facility beyond the patient's medical need for that facility's level of care creates a far higher care cost than should be incurred by either the patient or his insurer. A reduction of a single day of inpatient care for each Medicare beneficiary admitted to a hospital would result in savings of approximately $235 million in benefit expenditures.

In the medical insurance program, excessive or unnecessary utilization has substantial cost effects because of the fact that the common charge structure for medical services, whether in an outpatient hospital setting or in respect to services furnished by private physicians, is generally that a fee is charged for each visit. Under such a system, medical care costs can be substantially increased solely as a result of an increased number of visits which may or may not always represent a proportionate increase in either the quantity or quality of medical services rendered. Thus, if patients initiate physician or outpatient visits which their medical needs do not require or if they request additional visits after their current medical needs have been met, program liability can be considerably increased even though no medically necessary service is rendered. Similarly, there can be situations in which physicians and outpatient clinics may invite or allow more patient visits than are required for the patient's medical management or which customary practice would ordinarily dictate.

The program has approached its responsibilities in the area of cost control and utilization safeguards in a number of different ways. First, of course, the structure of the program itself provides some fundamental controls and safeguards. There are benefit limitations on the number of days of care in hospitals and extended care facilities and for home health visits. These limits are intended to assure coverage for the vast majority of medical situations that require these levels of service and yet provide upper limits which would tend to exclude some situations of excessive utilization. The program prescribes certain deductible and coinsurance amounts which may serve as a safeguard against the initiation of unnecessary services because they require the patient to share the cost of services and, thus, provide some motivation to him not to seek services unnecessarily or prolong services beyond his medical need. Particularly significant are the program requirements that, for services to be reimbursable, they must be furnished on a physician's order or under his direction and that for inpatient services to be reimbursable, a physician must certify, at periodic intervals, that they continue to be medically necessary.

Finally, section 1862(a)(1) of the Social Security Act provides that, under both the hospital and medical insurance programs, payment may not be made for services which are not reasonable and necessary for the diagnosis and treatment of illness and injury.

Another utilization safeguard mechanism on which Medicare places great reliance is utilization review. The law requires that every participating hospital and extended care facility have a committee, consisting of at least two physicians, to review the medical necessity of care furnished by the facility to Medicare patients. In their review of long-stay cases, these committees identify questionable cases which are then discussed with the attending physician for consideration of discharge or transfer to an alternative level of care. The decision of the committee that further care in the facility is not needed results in the termination of benefits. But beyond conserving program funds when benefits for unnecessary care are terminated, an effective committee also has a substantial influence on attending physicians which follows from their awareness that a committee of their peers is periodically reviewing extended institutional stays.

There is another dimension of utilization review which, in the long run, will be of even greater importance than the review of long-stay cases. The law also requires that each committee establish programs of sample review of admissions and professional services rendered by the facility with a view toward examining the medical necessity of such admissions and services and achieving a more effective utilization of health care facilities. The accumulation of data from this level of review and its periodic evaluation by the administrative and medical staff of each facility has great potential for improving the patient care practices of health facilities in the Nation.

In dealing with the problem of unwarranted escalation of costs and charges, intermediaries have considerably intensified their review of cost reports received from health facilities and, most particularly, carriers have intensified their review of bills submitted by physicians and suppliers. For health facilities, a cost analysis program is being developed to establish additional, more refined criteria for determining the reasonableness of individual provider costs in comparison with similar institutions in the same geographic area. Through these reviews, it is expected that a number of specific areas in which costs appear to be excessive for a given provider can be identified for further analysis. In addition, more sophisticated reviews of individual provider billings are increasingly being undertaken by intermediaries to evaluate services rendered in terms of various measures of medical appropriateness.

In respect to physician and supplier charge levels, the first step required has been the development of customary charge profiles for individual physicians and suppliers. These profiles serve as a basis for computation of prevailing charges, that is, the range of charges by most physicians and suppliers in given localities for similar services. As carriers improve these systems and particularly as they become automated, variations from customary and prevailing charges can be identified and subjected to review for reduction to the reasonable charge level of payment.

Although most carriers have developed customary and prevailing charge "screens," and are using them with some degree of effectiveness, some carriers have not yet established sufficiently dependable mechanisms. During fiscal year 1968, a great deal of effort was directed toward the establishment of effective review mechanisms by all carriers. This effort is, of course, continuing. Exhibit 3 in appendix D shows, at 6-month intervals during Medicare's first 2 years, the percent of services for which charge reductions were made and the amount and percent of reduction. The significant upward trend in each of these four semiannual periods reflects the intensification of carrier efforts in applying customary and prevailing charge screens and the increasing sophistication of such screens, in large part due to increased computer, rather than manual, screening processes.

In addition to customary and prevailing charge screens, a number of other utilization criteria have been or are being introduced into carrier systems. A particularly important screen, utilized by many carriers, permits the prompt identification of individual physicians whose total bills for Medicare patients in given periods significantly exceed what would normally be expected in ordinary practice. Investigation of physicians identified by means of such a screen can disclose instances of overutilization or cases in which the physician's practices are sufficiently questionable to warrant reporting to the State or local medical society or even cases of deliberate fraud in which prosecution would be appropriate. The increasing awareness that cases involving possibly excessive rates of payment are being investigated constitutes a significant deterrent to abuse. It should be noted, of course, that physicians identified by such a gross payment screen will, by no means, necessarily be engaged in improper practices. On the basis of a special study of payments to physicians reported by selected carriers for the period June 1966 through December 1967, 47 physicians within the areas served by these carriers were identified as receiving gross payments representing Medicare reimbursement exceeding $50,000 a year. Exhibit 4 in appendix D shows a breakdown of these physicians by specialty. In 13 of the cases, the carriers found no basis for questioning the services rendered. In the remaining 34 cases, however, the investigation is continuing and in some it is expected that there will be evidence of incorrect billing, or improper utilization and excessive charges. It should be noted that the cases investigated include a number of highly qualified specialists with extensive practices in urology, ophthalmology, internal medicine, and general surgery—areas in which one would expect a high incidence of utilization by aged patients—and that charges for services fell within acceptable ranges. Also, the Medicare payment figures represent gross income to the physician, without reflecting costs incurred by the physician in maintaining his practice. Exhibits 5 and 6 in appendix D show the preliminary results of the carriers' investigations. This type of carrier review will be intensified in fiscal 1969 and with increased computer capacity it can be performed more often on a gross billing basis coincident with payment.

Other types of screens which are being increasingly used by carriers provide for the identification of physician-patient contacts which appear abnormally frequent for a particular diagnostic category or therapeutic procedure, or for identification of potential markup situations where physicians include an added charge for services actually

provided by an independent laboratory, or the identification of situations in which a physician begins charging separately for component services which he had previously rendered as a combination or package service with a single charge. Carriers are increasingly incorporating such screens into their electronic data processing systems rather than applying them manually in the case-review process.

All of these efforts to preclude payment for unnecessary or excessive services greatly depend for their success on the support of the medical community, particularly in the establishment of norms which represent generally acceptable professional practices. The medical community has given substantial support to the efforts of many carriers in establishing such criteria. It should be noted, of course, that in many instances variations from usual patterns are justified by the facts of an individual case. The important thing, however, is that the Medicare claims review process must be able to identify significant variations so that further review can be undertaken in instances where the possibility of excessive or improper utilization should be investigated.

The area of utilization safeguards is a critically important area of program administration. The Administration is currently giving these aspects of intermediary and carrier performance the highest priority and intends to work closely with the intermediaries and carriers in the current fiscal year to develop uniformly effective claims review processes.

F. BENEFICIARY ENROLLMENT AND PREMIUM COLLECTION

Each month about 125,000 people reach age 65. The Social Security Administration makes an intensive effort to locate every eligible person to establish their entitlement to hospital insurance and offer them the opportunity to enroll in the voluntary medical insurance program.

Because they are already on the social security monthly benefit rolls, hospital insurance entitlement is automatically established for approximately one-half of the 125,000, and information on medical insurance enrollment can be promptly transmitted to this group by mail. Virtually all of the others are reached either through their own initiative, as urged in public informational programs, or through comprehensive "leads" programs utilizing a variety of techniques for identifying and informing those who are eligible.

About one-half of the over 60,000 who attain age 65 in any month, but who are not eligible for cash benefits, can be identified from combined social security and Internal Revenue Service sources. These people are advised by mail 3 months before they reach 65 of their right to enroll for both parts of Medicare. To reach the remainder, programs have been established with hundreds of large institutions and employers throughout the country through which people are identified as they approach 65 and are encouraged to contact their social security office. In addition, many of the Nation's health insurers include notices in their communication to policyholders who are approaching 65 as part of their invitation to purchase complementary coverage. Also of great help are the many public information messages conveyed through the mass media which emphasize the availability of hospital insurance and the importance of the decision on medical insurance enrollment for those approaching age 65.

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In addition to the 7-month initial medical insurance enrollment period for people who are approaching age 65 (beginning with the third month before the month they become 65, and ending 3 months after the month they become 65) there is an annual general enrollment period from January 1 through March 31, for those who either fail to enroll in their initial enrollment period, or who previously enrolled and had their coverage terminated. Extensive efforts were undertaken to advise persons who had not previously enrolled that another opportunity was available in the 6-month general enrollment period from October 1, 1967, through March 31, 1968. Records of the Social Security Administration were screened to identify all those who had not replied, or replied negatively, in their initial enrollment period and a mail recontact was made with this group. Internal Revenue records were again used to identify potential enrollees not shown on social security records. A broad publicity program was undertaken and many of the Nation's large insurers included special information in their subscriber communications. As a result, some 700,000 people were added to the medical insurance rolls in this period, in addition to those who enrolled as they reached age 65 during these months. As of July 30, 1968, almost 18,800,000 of the elderly—nearly 95 percent of those eligible—were enrolled in the medical insurance program.

Premium collection

The medical insurance program is financed through monthly premiums paid by those who enroll in the program and by equivalent matching payments made from the general revenues of the Federal Government. The premium rate through March 1968 was $3 per month. This amount was increased to $4 per month, beginning April 1968.

For people receiving social security cash benefits, railroad retirement benefits, or Federal civil service annuities, premiums are deducted from their monthly benefit checks. About half of those not receiving monthly benefits are billed quarterly for premiums by the Social Security Administration or Railroad Retirement Board. Premiums may be paid for as long as a year in advance, and for individuals financially unable to make quarterly payments, arrangements can be made for monthly payments.

The Social Security Administration also has group billing arrangements with 126 organizations which pay premiums on behalf of groups or enrollees. These group premium payment arrangements make it easier to integrate the group medical insurance plans with Medicare. Some organizations are required by collective bargaining contracts to pay premiums for members of the group; others provide medical care for their members and use medical insurance reimbursement to reduce the cost of such care to their members.

State buy-in activities

Under the Medicare law, as amended in 1967, States are permitted to enter into agreements with the Secretary, based on a request made before January 1, 1970, to buy in—that is, to enroll and pay the medical insurance premiums—for public assistance recipients age 65 or over who were receiving money payments under an approved public assistance plan and for all aged people eligible to receive medical assistance under an approved title XIX plan. The State may limit the agreement to cover only individuals (other than monthly social secu-

rity and railroad retirement beneficiaries) who are receiving money payments under an approved public assistance plan, or it may cover individuals including monthly social security and railroad retirement beneficiaries who are receiving money payments under an approved public assistance plan, or it may cover all aged persons determined eligible to receive medical assistance under title XIX, whether or not they receive monthly social security or railroad retirement benefits, or whether or not they receive money payments.

As of June 30, 1968, 39 States, Guam, and the Virgin Islands had active agreements enrolling approximately 1.6 million public assistance and medical assistance recipients in the supplementary medical insurance program. The increase in the number of buy-in States during the past year is largely attributable to the 1967 amendments which (1) extended the deadline for executing a buy-in agreement to December 31, 1969, and (2) provided that, after that date, there will be no Federal assistance toward the payment of medical expenses which would have been covered by supplementary medical insurance had the individual for whom the expenditure is made been enrolled in the program. It is expected that virtually all of the States will "buy in" before the January 1, 1970, deadline.

Termination of supplementary medical insurance coverage

People whose premiums are deducted from social security, railroad retirement, or Federal civil service retirement benefit checks—the vast majority of enrollees—had their first opportunity to voluntarily withdraw from the program during the 6-month general enrollment period that began on October 1, 1967. There were only about 40,000 such withdrawals in that period—a fraction of 1 percent of those eligible to disenroll—and, as previously noted, during the same period some 700,000 people who were eligible to enroll elected to start their coverage in the program.

Under the 1967 amendments, beneficiaries, effective with April 1, 1968, can give notice of withdrawal at any time, and their coverage will be terminated at the close of the following calendar quarter. There were approximately 7,000 such withdrawals in the April-June quarter of 1968, a voluntary withdrawal rate of about 0.15 percent on an annual basis.

In the second year of the program, a monthly average of 1.6 million people were billed directly for their premiums. Most of them were billed on a quarterly basis. As of the end of June 1968, there were about 150,000 unenrolled persons whose supplementary medical insurance coverage had been terminated for nonpayment of premiums. Terminations of enrollment for nonpayment of premiums were apparently due in many instances to the lack of financial resources for the premium. Many people terminated for nonpayment of premium were later reenrolled when their State public assistance programs entered into buy-in agreements for welfare or medical assistance recipients.

G. INCREASING PROGRAM UNDERSTANDING [21]

The achievements of Medicare in its first 2 years would not have been possible without a considerable understanding of the program by its millions of beneficiaries and by the entire health community. The

[21] A bibliography list of selected Medicare publications appears in app. E.

informational activities which accomplished this have not been conducted solely by the Social Security Administration and the intermediaries and carriers, but have involved the assistance and cooperation of innumerable organizations outside of Government.

Improving beneficiary understanding

The main effort in reaching program beneficiaries is in the issuance of written materials. The major written vehicle which SSA relies on to inform beneficiaries of their Medicare benefits and how to receive them is the publication titled "Your Medicare Handbook." The handbook was first distributed to beneficiaries when the program began in July 1966. It remained as the most comprehensive source of information on Medicare until the passage of the 1967 amendments which obsoleted major portions of the old handbook.

Twenty-three million copies of a revised edition were issued in May and June 1968. In preparing the new Medicare handbook, comments were secured from the program's intermediaries and carriers, as well as major organizations in the health care field. Social security staff members in SSA's district offices were asked for recommendations based on their thousands of contacts with beneficiaries since the issuance of the first handbook. An extensive review was made of beneficiary correspondence over the preceding 2 years reflecting their problems in understanding Medicare provisions. Early drafts of the revised handbook were reviewed by a panel of seven experts in public communications, and a pilot test of the new handbook was undertaken with beneficiaries in a small community in Maryland. The new edition was a marked change from the old handbook. Colors were used to separate the sections describing the hospital insurance and medical insurance parts of the program. The language level was carefully gaged to assure a greater degree of beneficiary understanding, and the confusing term "spell of illness" was changed to "benefit period." A special index was prepared so that beneficiaries could readily identify the special program changes brought about by the 1967 amendments. A new section was included which emphasized blood replacement opportunities through the American Red Cross and the American Association of Blood Banks, calling particular attention to the fact that replacement was often possible because of a relative's membership in a blood donor plan.

Separate handbooks were prepared and distributed for those who had hospital insurance only or medical insurance only. The Railroad Retirement Board prepared a modified version for its beneficiaries.

It was clear that a single handbook encompassing all of the benefits available under Medicare could only meet part of the overall informational needs of beneficiaries. A great deal of emphasis has, therefore, been placed on making informational literature available to beneficiaries at the location where they actually receive covered services. Through this technique, information which is specifically related to the service he is receiving can be brought to the beneficiary's attention at the time when it is most relevant. Moreover, when the beneficiary reads such descriptive material at the location where services are being received, the assistant in the physician's office or the employees of a health facility are available to provide additional information and answer any questions which the beneficiary may have.

A number of pamphlets and brochures of this kind have been prepared and distributed to beneficiaries, hospitals, extended care facilities, home health agencies, and physicians' offices. These pamphlets cover specific program areas; for example, "When You Enter a Hospital"; "Outpatient Hospital Benefits"; "How To Claim Benefits Under Medical Insurance."

SSA's 779 district offices and 3,241 regularly visited contact stations provide readily accessible informational service to the public through personal contacts and in response to telephone and letter inquiries. These direct beneficiary services extend from answering questions to assisting in the completion of claims forms. In fiscal year 1968, SSA recorded close to 11 million district office Medicare inquiries and an additional 2,700,000 claims assistance actions on behalf of beneficiaries. District offices also engage in extensive informational activities through their access to more than 12,000 newspapers, 1,830 magazines, 3,786 radio stations, and 708 television stations. Regular releases are furnished to these outlets and district office staff frequently appear on radio and television programs. District office staff made over 41,000 talks in fiscal year 1968 before civic and professional audiences and placed over 4,000 exhibits at conventions, libraries, and other public locations. Much of the material distributed or displayed through these outlets represented information on Medicare.

Intermediaries and carriers have engaged in substantial public information activities, ranging from the establishment of public inquiry sections in their operations for handling telephone and mail contacts, to the involvement, particularly by carriers, in numerous public appearances at meetings of beneficiaries, civic groups, and similar audiences. In addition, many intermediaries and carriers include Medicare information in their communications to their own subscribers, particularly those who have coverage complementary to Medicare. Further, a substantial part of intermediary and carrier communications to the health community conveys beneficiary-related information, so that physicians and their assistants as well as health care personnel in hospitals and other facilities are able to act as sources of Medicare information to beneficiaries.

Informing the health community

A primary source of Medicare information to physicians has been the publication entitled "Medicare—A Reference Guide for Physicians." This publication was first issued in May 1966 and distributed to all of the Nation's physicians as well as to providers and major organizations in the health community.

In developing a revised version of the Reference Guide to incorporate the 1967 amendment changes, the same intensive effort was engaged in to achieve an improved product as in the case of the new Medicare handbook for beneficiaries. Of particular value was the cooperation of the American Medical Association through their selection of a panel of physicians to review and advise SSA on the new edition.

Copies of the new Reference Guide were mailed in August 1968 to all of the Nation's physicians and every major organization in the health community.

Another SSA publication, transmitted by carriers to physicians' offices, was the small brochure, "Notes for the Office Assistant." This

brochure provided a brief explanation of the claims process for medical insurance reimbursement, describing both the assignment and direct billing methods of claims submission, and included specific information on how to complete the SSA–1490, the "Request for Medicare Payment" form.

Intermediaries and carriers have developed a wide variety of communication media addressed to the health community. Most of them utilize regular issuances to transmit program information directly to physicians and providers of services. In addition to these regular written communications, active orientation and training programs are conducted with groups of office assistants and key personnel of hospitals, extended care facilities, and home health agencies. These meetings not only have permitted intermediaries and carriers to transmit a considerable body of essential program information to these audiences but, more importantly, has afforded the health community a significant opportunity to identify specific problems and make recommendations to intermediaries and carriers for specific information materials or activities which would overcome these problems. Intermediaries and carriers also take part in many health community conventions and related meetings, usually appearing as featured speakers, panel members, or resource persons available to answer the questions of those attending the meetings. In addition, numerous articles have been prepared by intermediaries and carriers for publication in health community journals and other media.

SSA, through its central office and regional offices, has developed effective informational relationships with the major national organizations in the health care field and with the major national publications reaching the health care community. The AMA News has been extremely helpful in publishing program information of value to physicians and in defining the physicians' important role in assuring proper utilization of Medicare services and in assisting patients to secure Medicare benefits.

H. COORDINATION OF MEDICARE AND STATE MEDICAL ASSISTANCE PROGRAMS

Medicare and the State medical assistance programs, commonly called medicaid, have worked closely together since 1966 both at the Federal and State levels in an effort to achieve consistent and compatible policies and procedures governing reimbursement, health care standards, and claims processing. The 1967 amendments to both titles XVIII and XIX of the Social Security Act significantly increased the need for such coordination.

Increasingly effective measures to facilitate the processing of claims in which payment may be made under both programs have been implemented in most States. In general, the policy is that the Social Security Administration will furnish information pertinent to processing medical assistance claims and, whenever appropriate, will share operations with medical assistance programs in the interest of reducing total Federal spending. The Social Security Administration will pay the full cost of those operations which are necessary for title XVIII, even though they may also benefit a medical assistance program. The medical assistance program, however, will pay for those

operations or costs not necessary to the title XVIII process. Common Medicare and medical assistance claims forms have been developed and common provider cost report forms and audits are being developed. Where there is a common carrier in a State for both programs, authorization has been granted to issue a single check combining payments for each program.

Beginning July 1, 1967, hospitals participating in the title XIX program, as well as title V programs for crippled children, were required to use title XVIII's principles of reimbursement for provider costs in determining payment for services rendered to beneficiaries of these two programs. Thus, the development of new or revised principles of hospital cost reimbursement became a cooperative effort by all three programs. A coordinating committee has been established consisting of representation from the Social and Rehabilitation Service and the Social Security Administration. Contemplated changes in cost principles, intermediary letters, and replies to inquiries which require the adoption of new or revised positions are being cleared by the respective parties.

During fiscal year 1968, the Social Security Administration and the Social and Rehabilitation Service established an interagency committee to explore potential reductions in the cost of provider audits through the development of a common cost report and a common audit program meeting the requirements of title XVIII, title XIX, and title V. We reached agreement with the Social and Rehabilitation Service on the basic issues relating to this policy and hope that within the next fiscal year we will be able to implement this policy. When it becomes fully effective, we anticipate that auditing costs for the Medicare program will be reduced by $3.5 million.

The 1967 amendments also introduced additional conditions for Federal reimbursement in the various health care programs under title XIX, which necessitated joint consideration and a unified approach. Particularly significant were the provisions relating to utilization of care and services under title XIX, standards for skilled nursing homes receiving Federal financial assistance under title XIX, and assistance in the form of services in intermediate care facilities.

Effective April 1, 1968, the States were required to establish methods and procedures designed to safeguard against unnecessary utilization of care and services furnished under title XIX plans. The Social Security Administration together with representatives of the Public Health Service and the Social and Rehabilitation Service have collaborated in the formulation of a policy statement to implement this statutory provision. Certain coordination problems have arisen as a result of this requirement. Instructions issued thus far have encouraged (but do not require) the delegation of the function of evaluating utilization review to the agencies doing this work under title XVIII. The Social and Rehabilitation Service's policy provides in effect that any facility subject to utilization review under Medicare will not be subject to different utilization review standards for medicaid; however, a State may at its option establish different requirements for facilities that do not participate in Medicare. It will be important to obtain feedback as to variances in utilization review requirements, the extent

of delegations, and problems encountered where different agencies carry out title XVIII and title XIX functions.

The Social Security Amendments of 1967 introduced standards which will become applicable over a period of several years to skilled nursing homes participating under title XIX. In addition, effective January 1, 1968, States are authorized to make vendor payments on behalf of cash assistance recipients in facilities which furnish more than room and board but less than skilled nursing care. These are termed "intermediate care facilities." An evaluation and approval program for such facilities, similar to the title XVIII certification process, is being developed by the Social and Rehabilitation Service. Coordination has been carried out in several areas pertinent to this process, and standards have been drafted which will be submitted for publication in the Federal Register. A single survey approach will be applied where feasible, under which the inspection and evaluation of a facility will simultaneously serve the purpose of State licensure, Medicare, and medicaid.

The 1967 amendments also provided that, effective July 1, 1968, States will receive 75 percent Federal matching funds under title XIX for consultation to help health facilities qualify for participation in the various Federal health programs. When this provision goes into effect the current 100 percent funding of the consultation function, under title XVIII only, will be discontinued. Initial steps have been taken to assure coordinated efforts by the Social and Rehabilitation Service, the Public Health Service, and the Social Security Administration in implementing this new provision, in properly allocating Federal funding between the agencies and appropriately relating the consultation function to the ongoing title XVIII certification process.

APPENDIXES

Appendix A

Principal Changes in Medicare Made by the 1967 Amendments

PAYMENT FOR PHYSICIANS' AND OTHER SERVICES MAY BE MADE ON UNPAID BILLS

If no assignment is taken, medical insurance payments may now be made directly to the patient on the basis of an itemized bill—even though it has not been paid. There is no change in the assignment method under which physicians and suppliers may have payment made directly to them. This new provision applies to all bills received or processed by carriers on or after January 2, 1968 (the date of enactment) even though the services were rendered before that date.

TIME LIMIT FOR FILING MEDICAL INSURANCE BILLS (PAID OR UNPAID)

In order for payment to be made on a bill it must be submitted before December 31 of the year following the year in which services are received. For purposes of this rule, services received in the last 3 months of a calendar year are counted as received in the following year; thus, bills for such services may be submitted until December 31 of the second year after the year in which services were actually received.

A special extension permitted bills for covered services received in July, August, or September 1966, to be submitted until March 31, 1968.

ELIMINATION OF CERTAIN PHYSICIAN CERTIFICATIONS

Physician certification of medical necessity for virtually all outpatient hospital services and admissions to general hospitals has been eliminated. The provision applies to admissions and to outpatient services furnished on and after January 2, 1968. The first certification for inpatient services in a general hospital will now be required as of the 14th day of services. Certification on admission is still required for admissions to psychiatric and tuberculosis hospitals and to extended care facilities.

ADDITIONAL INPATIENT HOSPITAL BENEFIT DAYS (EFFECTIVE JANUARY 1, 1968)

Each hospital insurance beneficiary will have a "lifetime reserve" of 60 additional days of inpatient hospital coverage. These additional days can be used at the patient's option whenever the 90 days covered in a "spell of illness" have been exhausted, and are subject to $20 a day coinsurance. This benefit is not renewable; the number of days in a beneficiary's "lifetime reserve" is permanently reduced by the number of days used.

FULL REIMBURSEMENT OF RADIOLOGY AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS (EFFECTIVE APRIL 1, 1968)

Payment of the full reasonable charges may be made under medical insurance for radiology and pathology services furnished by physicians to inpatients of participating hospitals. The $50 annual deductible does not have to be met. Thus, because there will rarely be any patient liability for these services, Medicare reimbursement procedures can be greatly facilitated and the patient can frequently be left out of the process completely.

Under this provision, it will also be possible to pay for radiology and pathology services to hospital inpatients in a manner that is more consistent with the usual billing procedures of many hospitals and the manner in which these services are reimbursed by most other health insurance programs. Where the hospital customarily bills for both the hospital's services and the services of the pathologists and radiologists, the absence of the medical insurance deductible and coinsurance will now make it unnecessary to break down the bill on a patient-by-patient basis into the parts covered under the hospital insurance and medical insurance programs, since this can be done on an aggregate basis. Thus, where the total services are billed through the hospital, the provision would provide opportunities for the development of hospital billing procedures that will greatly reduce paperwork and facilitate administration.

INCLUSION OF ALL OUTPATIENT HOSPITAL BENEFITS UNDER MEDICAL INSURANCE (EFFECTIVE APRIL 1, 1968)

This provision consolidates all covered outpatient hospital services under the medical insurance program. Thus, there will be only a single deductible and coinsurance applied to *all* covered outpatient hospital services (the $50 annual medical insurance deductible and 20 percent coinsurance), and no need to separate diagnostic from therapeutic services as in the past, for allocation of costs and charges to different parts of the Medicare program.

Also, effective April 1, 1968, hospitals may, in situations described in regulations, collect an outpatient charge of $50 or less from the beneficiary. This provision will simplify hospital collection processes in situations where the hospital cannot readily determine whether the patient has met the deductible, and he is able to pay the bill at the time services are rendered. Where such collections are made, the beneficiary would ordinarily receive the medical insurance reimbursement on the basis of a claim prepared on his behalf by the hospital. Payments to the hospital will be periodically adjusted to assure that total hospital reimbursement for outpatient services does not exceed what the hospital would have received if it had submitted all bills on a cost reimbursement basis.

PAYMENT FOR ADDITIONAL OUTPATIENT PHYSICAL THERAPY SERVICES (EFFECTIVE JULY 1, 1968)

Physical therapy services previously have been covered only when furnished under the direct supervision of a physician or to homebound patients under a home health plan. Effective July 1, 1968, physical therapy services will also be covered under the medical insurance program when furnished by qualified providers of services or others under arrangements with, and under the supervision of, such providers. For purposes of this additional coverage, the term "providers of services" includes approved clinics, rehabilitation agencies and public health agencies. In order for payment to be made for such services, a physician must certify that the patient requires physical therapy services on an outpatient basis, and is under a plan of treatment established and periodically reviewed by a

physician which prescribes the type, amount, and duration of the services. The patient does not need to be confined to his home.

PAYMENT UNDER MEDICAL INSURANCE FOR CERTAIN ANCILLARY SERVICES NOT PAYABLE UNDER HOSPITAL INSURANCE (EFFECTIVE APRIL 1, 1968)

Under this provision, payment can be made under medical insurance for certain ancillary services furnished by a hospital or extended care facility for which no payment can be made under hospital insurance. This provision would apply, for example, where a patient has exhausted his hospital insurance eligibility or where an extended care facility patient has not met the prior hospitalization requirement. These benefits are subject to the $50 deductible and 20 percent coinsurance.

INCLUSION OF CERTAIN PODIATRISTS' SERVICES AND GENERAL EXCLUSION OF SPECIFIED FOOT CARE SERVICES (EFFECTIVE JANUARY 1, 1968)

Services of doctors of podiatry or surgical chiropody are covered under the medical insurance program as physicians' services, but only with respect to functions which they are authorized to perform by the State where they practice. However, certain specified foot care services will now be excluded whether performed by a podiatrist or medical doctor. These exclusions include treatment of flat foot conditions, the prescription of supportive devices for such conditions, treatment of subluxations of the foot, and routine foot care (including cutting or removal of corns, warts or callouses, trimming of nails and other routine hygienic care).

SPECIFIC EXCLUSION OF EYE REFRACTIONS

All procedures performed during any eye examination on and after January 2, 1968, to determine the refractive state of the eyes (even in connection with furnishing prosthetic lenses) are now excluded from coverage. The exclusion applies whether the refractions are performed by ophthalmologists, other physicians, or optometrists, and even though the total examination is for the treatment or diagnosis of eye disease or injury.

PAYMENT FOR PURCHASE OF DURABLE MEDICAL EQUIPMENT (EFFECTIVE JANUARY 1, 1968)

In addition to payment for rental, payment can also be made for purchase of durable medical equipment by or for an individual. Except for inexpensive items, payment will be made periodically in the same amount as if the equipment were rented, but only for the period of time that the equipment is medically necessary or until the purchase price has been met, whichever occurs first.

PAYMENT FOR PORTABLE X-RAY SERVICES (EFFECTIVE JANUARY 1, 1968)

Payment will be made for diagnostic X-ray services furnished in the patient's home or other place of residence. These services will be covered under medical insurance if they are provided under the general supervision of a physician and if they meet health and safety regulations.

BLOOD DEDUCTIBLES (EFFECTIVE JANUARY 1, 1968)

Under this provision, the definition of "blood" is broadened to include packed red blood cells as well as whole blood. A 3-pint blood deductible will now also apply to the medical insurance program for blood furnished during a calendar year in connection with services covered by that program. This deductible is separate from the 3-pint blood deductible for each "spell of illness" in the hospital insurance program, and neither can be used to meet the other.

PAYMENT FOR SERVICES FURNISHED TO INPATIENTS OF NONPARTICIPATING HOSPITALS

Under this provision, partial payment may be made for inpatient emergency or nonemergency services furnished by certain nonparticipating hospitals between July 1, 1966, and January 1, 1968, and for emergency inpatient services furnished by certain nonparticipating hospitals in respect to admissions on or after January

1, 1968. A facility is considered a hospital under this provision if it is licensed as a hospital, has a full-time nursing service, and is primarily engaged in furnishing medical care under the supervision of a doctor of medicine or osteopathy. Hospital insurance will pay 60 percent of the room and board charges and 80 percent of other charges for covered services after the usual deductibles are met. These benefits are limited to 20 days if the hospital does not qualify to take part in Medicare, but if the hospital begins to participate in Medicare before January 1, 1969, and applies its utilization review plan to the services rendered, the full duration of hospital insurance benefits can apply.

INCENTIVE REIMBURSEMENT EXERIMENTATION

The Secretary of Health, Education, and Welfare is authorized to experiment with alternative methods of reimbursement to organizations and physicians under the Medicare, medicaid, and child health programs. The experiments would test various incentives for increasing the efficiency and economy of health services without adversely affecting the quality of care. Experiments may involve only those physicians, institutions, and organizations that agree to participate and may not be initiated until the Secretary obtains the advice and recommendations of specialists competent to evaluate the possibility of securing productive results.

ADVISORY COUNCIL STUDY OF HEALTH INSURANCE FOR THE DISABLED

An advisory council, to be appointed in 1968, will study the question of providing health insurance protection for the disabled under title XVIII. The council will make its recommendations to the Secretary not later than January 1, 1969.

CHANGES IN REDUCTION OF BENEFIT DAYS FOR PSYCHIATRIC AND TUBERCULOSIS TREATMENT (EFFECTIVE JANUARY 1, 1968)

Any inpatient days in a psychiatric or tuberculosis hospital in the 90-day period before his hospital insurance coverage began have previously counted against a beneficiary's days of coverage during his first "spell of illness." This provision has been modified as follows:

1. The reduction will not apply to tuberculosis hospitals.
2. The provision no longer prevents payment for inpatient services in a general hospital unless the services are primarily for the diagnosis or treatment of mental illness and the spell of illness began in a psychiatric hospital.
3. The applicable period prior to hospital insurance eligibility has been extended from 90 to 150 days to reflect the new lifetime reserve of 60 additional inpatient hospital days.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The 1967 amendments expand the responsibilities of the Health Insurance Benefits Advisory Council to include reviewing the utilization of services under Medicare and making recommendations for program changes.

STUDY OF DRUG PROPOSALS

The Secretary will study a proposal to establish quality and cost standards for drugs for which payment is made under the Social Security Act, and a proposal to cover drugs under the medical insurance program. He is required to report his findings and recommendations to the President and the Congress by January 1, 1969.

COVERAGE OF SERVICES OF ADDITIONAL HEALTH PRACTITIONERS

The Secretary will study the need for extension of coverage under the medical insurance program to the services of additional types of licensed practitioners performing health services in independent practice. He will make recommendations to the Congress prior to January 1, 1969.

HOSPITAL INSURANCE ELIGIBILITY

Individuals reaching age 65 prior to 1968 were eligible for hospital insurance benefits, under a "transitional insured status" provision, even though they did not have any social security work credits. Under the new law, people who reach

65 in 1968 and are not entitled to monthly social security or railroad retirement benefits will need three calendar quarters—about three-fourths of a year—of social security work credits, in order to be eligible for hospital insurance.

For people who reach 65 after 1968, the amount of work credits needed increases by three quarters each year—six quarters will be needed by those who reach 65 in 1969, nine by those who reach 65 in 1970, and so on. Eventually, the amount of work required for hospital insurance protection will be the same as that required for monthly cash benefits.

However, a person who qualifies for monthly benefits as the dependent or survivor of an insured worker will not need any work credits.

MEDICAL INSURANCE ENROLLMENT

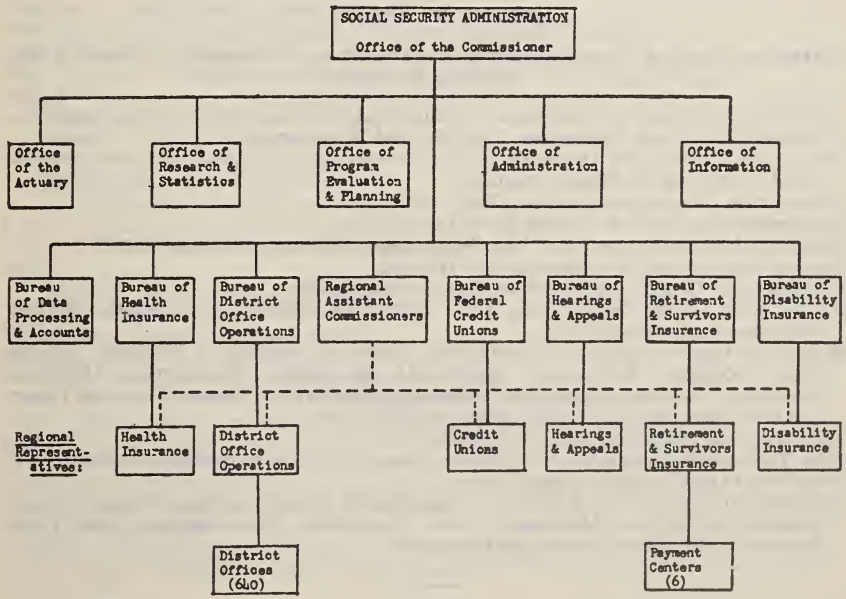
Changes were also made in the provisions for medical insurance enrollment. A person who is not enrolled for medical insurance may enroll during the first 3 months of any year, provided this period begins within 3 years after he had his first opportunity to enroll. People already 65 or older who do not have medical insurance could enroll through April 1, 1968; if they did not enroll by that date, they will have to wait until 1969 for another opportunity to do so.

A person who is enrolled for medical insurance may give notice of his intention to drop the insurance at any time. The notice is effective at the end of the next calendar quarter (except for notices received on or before April 1, 1968, which were effective on that date). He may re-enroll during the first 3 months of any year, but only if he does so within 3 years after his coverage is terminated.

APPENDIX B

EXHIBIT 1

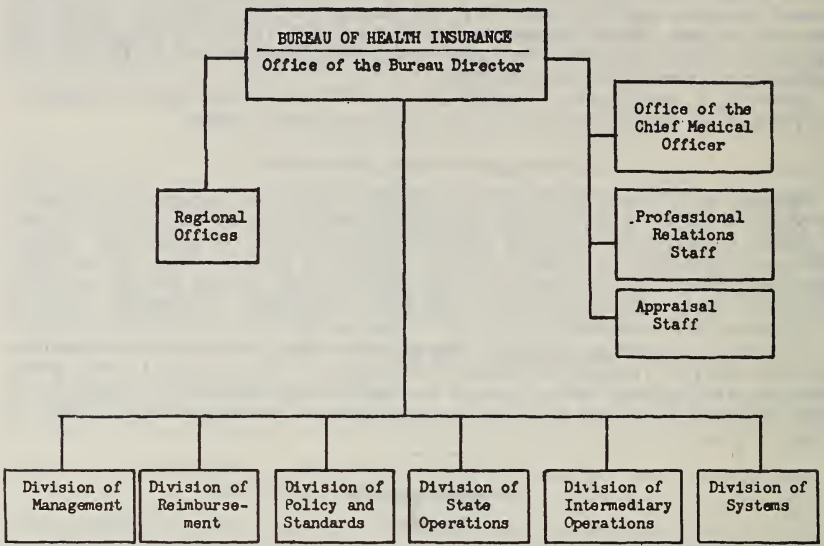
SOCIAL SECURITY ADMINISTRATION ORGANIZATION CHART



March 1968

Appendix B—Exhibit 2

Bureau of Health Insurance Organization Chart



Appendix B—Exhibit 3

Intermediaries for Hospital Insurance Program and States in Which They Service Providers

Aetna Life & Casualty: California, Connecticut, Florida, Illinois, Massachusetts, Nevada, New York, Tennessee, Virginia, and Washington.
Blue Cross Association (through 74 Blue Cross plans): All States except Hawaii and Nevada and the Virgin Islands.
Community Health Association (CHA): Michigan.
Cooperativa de Salud de Puerto Rico: Puerto Rico.
Hamilton Life Insurance Co.: New York (extended care facilities only)*
Hawaii Medical Service Association: Hawaii.
Inter-County Hospitalization Plan, Inc.: Pennsylvania.
Kaiser Foundation Health Plan, Inc.: California, Hawaii, and Oregon (Kaiser Foundation providers only).
Mutual of Omaha: Alabama, California, Colorado, District of Columbia, Idaho, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Oklahoma, Oregon, South Dakota, Texas, Virginia, Virgin Islands, Washington, West Virginia, and Wisconsin.
Nationwide Mutual Insurance Co.: Ohio.
New York State Department of Health: New York (home health agencies only).
Prudential Insurance Co.: New Jersey.
Travelers Insurance Co.: California, Connecticut, Florida, Georgia, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Mexico, New York, Pennsylvania, Rhode Island, and Vermont.

Appendix B—Exhibit 4

Carriers for Medical Insurance Program

Alabama: Blue Cross-Blue Shield of Alabama.[1]
Alaska: Aetna Life & Casualty.
Arizona: Aetna Life & Casualty.
Arkansas: Arkansas Blue Cross & Blue Shield, Inc.[1]

*Effective May 1968, Travelers Insurance Co. became the intermediary for New York extended care facilities.
[1] Blue Shield Plan.

California :
    California Blue Shield.[1]
    Occidental Life Insurance Co. of California.
Colorado : Colorado Medical Service, Inc.[1]
Connecticut : Connecticut General Life Insurance Co.
Delaware : Blue Cross & Blue Shield of Delaware, Inc.[1]
District of Columbia : Medical Service of the District of Columbia.[1]
Florida : Blue Shield of Florida, Inc.[1]
Georgia : John Hancock Mutual Life Insurance Co.
Hawaii : Aetna Life & Casualty.
Idaho : The Equitable Life Assurance Society of the United States.
Illinois :
    Continental Casualty Co.
    Illinois Medical Service.[1]
Indiana : Mutual Medical Insurance, Inc.[1]
Iowa : Iowa Medical Service.[1]
Kansas : Blue Cross-Blue Shield of Kansas.[1]
Kentucky : Metropolitan Life Insurance Co.
Louisiana : Pan-American Life Insurance Co.
Maine : Union Mutual Life Insurance Co.
Maryland : Maryland Medical Service, Inc.[1]
Massachusetts : Massachusetts Medical Service.[1]
Michigan : Michigan Medical Service.[1]
Minnesota :
    Blue Shield of Minnesota.[1]
    The Travelers Insurance Co.
Mississippi : The Travelers Insurance Co.
Missouri :
    General American Life Insurance Co.
    Surgical Care, Inc.[1]
Montana : Montana Physicians' Service.[1]
Nebraska : [2] Mutual of Omaha Insurance Co.
Nevada : Aetna Life & Casualty.
New Hampshire : New Hampshire-Vermont Physician Service.[1]
New Jersey : The Prudential Insurance Co. of America.
New Mexico : The Equitable Life Assurance Society of the United States.
New York :
    Blue Shield of Western New York, Inc.[1]
    Genesee Valley Medical Care.[1]
    Group Health Insurance, Inc.
    Metropolitan Life Insurance Co.
    United Medical Service, Inc.[1]
North Carolina : Pilot Life Insurance Co.
North Dakota : North Dakota Physicians Service.[1]
Ohio :
    Medical Mutual of Cleveland, Inc.[1]
    Nationwide Mutual Insurance Co.
Oklahoma : [3] Aetna Life and Casualty.
Oregon : Aetna Life and Casualty.
Pennsylvania : Pennsylvania Blue Shield.[1]
Puerto Rico : Seguros de Servicio de Salud de Puerto Rico, Inc.
Rhode Island : Rhode Island Medical Society Physicians Service.[1]
South Carolina : Blue Cross—Blue Shield of South Carolina.[1]
South Dakota : South Dakota Blue Shield.[1]
Tennessee : The Equitable Life Assurance Society of the United States.
Texas : Group Medical and Surgical Service.[1]
Utah : Medical Service Bureau.[1]
Vermont : New Hampshire-Vermont Physician Service.[1]
Virgin Islands : Mutual of Omaha Insurance Co.

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[1] Blue Shield Plan.
[2] The Nebraska State Department of Public Welfare was among the initial carrier selections. However, the agreement was terminated by mutual consent effective May 5, 1967, following a request by the Department of Public Welfare.
[3] As of July 1, 1967, the Oklahoma Department of Public Welfare assumed the carrier role for those individuals included in the "buy-in" agreement.

Virginia :
Medical Service of the District of Columbia.[1]
The Travelers Insurance Co.
Washington : Washington Physicians Service.[1]
West Virginia : Nationwide Mutual Insurance Co.
Wisconsin :
Medical Society of Milwaukee County.[1]
Wisconsin Physicians Service.[1]
Wyoming : The Equitable Life Assurance Society of the United States.

Appendix B—Exhibit 5

State Agencies Administering Provider Certification

Alabama : State Department of Public Health, Montgomery, Ala.
Alaska : Alaska Department of Health and Welfare, Juneau, Alaska.
Arizona : State Department of Health, Phoenix, Ariz.
Arkansas : State Board of Health, Little Rock, Ark.
California : State Department of Public Health, Berkeley, Calif.
Colorado : State Department of Public Health, Denver, Colo.
Connecticut : State Department of Health, Hartford, Conn.
Delaware : State Board of Health, Dover, Del.
District of Columbia : District of Columbia Health Department, Washington, D.C.
Florida : State Board of Health, Jacksonville, Fla.
Georgia : Georgia Department of Public Health, Atlanta, Ga.
Guam : Department of Public Health and Welfare, Agana, Guam.
Hawaii : Hawaii Department of Health, Honolulu, Hawaii.
Idaho : Idaho Department of Health, Boise, Idaho.
Illinois : Illinois Department of Public Health, Springfield, Ill.
Indiana : State Board of Health, Indianapolis, Ind.
Iowa : State Department of Health, Des Moines, Iowa.
Kansas : State Department of Health, Topeka, Kans.
Kentucky : Commonwealth of Kentucky Department of Health, Frankfort, Ky.
Louisiana : Louisiana Department of Hospitals, Baton Rouge, La.
Maine : Maine Department of Health and Welfare, Augusta, Maine.
Maryland : State Department of Health, Baltimore, Md.
Massachusetts : Massachusetts Department of Public Health, Boston, Mass.
Michigan : Michigan Department of Health, Lansing, Mich.
Minnesota : State Department of Health, Minneapolis, Minn.
Mississippi : Mississippi State Board of Health, Jackson, Miss.
Missouri : Division of Health, Jefferson City, Mo.
Montana : State Board of Health, Helena, Mont.
Nebraska : State Department of Health, Lincoln, Neb.
Nevada : Division of Health, Carson City, Nev.
New Hampshire : New Hampshire Division of Public Health, Concord, N.H.
New Jersey : State Department of Health, Trenton, N.J.
New Mexico : New Mexico Department of Public Health, Sante Fe, N. Mex.
New York : New York State Department of Health, Albany, N.Y.
North Carolina : State Board of Health, Raleigh, N.C.
North Dakota : State Department of Health, Bismarck, N. Dak.
Ohio : Ohio Department of Health, Columbus, Ohio.
Oklahoma : State Department of Health, Oklahoma City, Okla.
Oregon : State Board of Health, Portland, Oreg.
Pennsylvania : Department of Health, Harrisburg, Pa.
Puerto Rico : Puerto Rico Department of Health, San Juan, P.R.
Rhode Island (except extended care facilities) : Rhode Island Department of Health, Providence, R.I.
Rhode Island (extended care facilities only) : Rhode Island Department of Social Welfare, Providence, R.I.
South Carolina : State Board of Health, Columbia, S.C.
South Dakota : State Department of Health, Pierre, S. Dak.
Tennessee : Tennessee Department of Public Health, Nashville, Tenn.
Texas : State Department of Health, Austin, Tex.
Utah : State Department of Health, Salt Lake City, Utah.

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[1] Blue Shield Plan.

Vermont: Vermont Department of Health, Burlington, Vt.
Virgin Islands: Virgin Islands Department of Health, St. Thomas, V.I.
Virginia: State Department of Health, Richmond, Va.
Washington: State Department of Health, Olympia, Wash.
West Virginia: State Department of Health, Charleston, W. Va.
Wisconsin: State Board of Health, Madison, Wis.
Wyoming: State Department of Public Health, Cheyenne, Wyo.

NOTE.—The government of American Samoa, the sole operator of medical facilities in that territory, has appointed an administrative officer to confer with DHEW with regard to the Medicare program.

APPENDIX B—EXHIBIT 6

GROUP PRACTICE PREPAYMENT PLANS REIMBURSED DIRECTLY BY SSA ON REASONABLE COST BASIS

Atcheson, Topeka, and Santa Fe Hospital Association, Topeka, Kans.
Boro Medical Center, New York, N.Y.
Community Health Association, Detroit, Mich.
Community Health Foundation, Cleveland, Ohio
Family Health Program of Southern California, Long Beach, Calif.
Group Health Cooperative of Puget Sound, Seattle, Wash.
Group Health Plan, Inc., St. Paul, Minn.
Health Insurance Plan of Greater New York, New York, N.Y.
Kaiser Foundation Health Plan, Inc., Oakland, Calif.
La Societe Francaise de Bienfaisance Mutuelle, San Francisco, Calif.
Local 1205 Health Center, Brooklyn, N.Y.
Medical Institute of Local 88, St. Louis, Mo.
NYSA–ILA Coordinating Committee, New York, N.Y.
NYSA–PWU Welfare Fund, New York, N.Y.
Philadelphia AFL–CIO Hospital Association, Philadelphia, Pa.
Police and Firemen's Medical Association, Philadelphia, Pa.
Santa Fe Coast Lines Hospital Association, Los Angeles, Calif.
Southern Pacific Employees Hospital Association, San Francisco, Calif.
St. Louis Labor Health Institute, St. Louis, Mo.
Union Family Medical Fund of the Hotel Industry of NYC, New York, N.Y.
United Mine Workers of America Retirement and Welfare Fund, Washington, D.C.
Wabash Memorial Hospital Association, Decatur, Ill.
Western Clinic, Tacoma, Wash.

APPENDIX B—EXHIBIT 7

MEMBERS OF THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

(As of June 14, 1968)

Charles L. Schultze, Chairman, professor of economics, University of Maryland; senior fellow, Brookings Institution; former Director of the Bureau of the Budget.
Bernard Bucove, M.D., Health Services Administrator of New York City; former director, Washington State Health Department; past president and former member of the executive committee of the Association of State and Territorial Health Officers.
Kenneth W. Clement, M.D., past president, National Medical Association; practicing surgeon, Cleveland, Ohio.
Nelson H. Cruikshank, former director, Department of Social Security, AFL–CIO.
Margaret B. Dolan, professor and head, Department of Public Health Nursing, University of North Carolina School of Public Health; past president of the American Nurses' Association.
C. Manton Eddy, past president, Health Insurance Association of America; director, Aetna Insurance Co.; director, Connecticut General Life Insurance Co.

Caldwell B. Esselstyn, M.D., associate program coordinator, New York Metropolitan Regional Medical Program, Associated Medical Schools of New York; former chairman and presently a member of the board of the Group Health Association of America; former executive director of the Community Health Association, Detroit, Mich.

Merrill O. Hines, M.D., medical director and chairman of the Board of Management, Ochsner Clinic; professor of clinical surgery, Tulane Medical School.

William R. Hutton, executive director and director of information, National Council of Senior Citizens, Inc.; editor, Senior Citizens News.

The Very Reverend Monsignor Harrold A. Murray, director, Bureau of Health and Hospitals, United States Catholic Conference.

Russell A. Nelson, M.D., president, The Johns Hopkins Hospital, Baltimore, Md.; past president, American Hospital Association.

Howard P. Rome, M.D., senior consultant in psychiatry, Mayo Clinic, Rochester, Minn.; councillor and past president, American Psychiatric Association; professor of psychiatry, Mayo Graduate School of Medicine, University of Minnesota.

Syble H. Scott, practicing attorney; nursing home operator; faculty member, School of Continuing Education, University of Oklahoma.

Samuel R. Sherman, M.D., former chairman, Council on Legislative Activities, American Medical Association; planning officer, Mount Zion Hospital, San Francisco, Calif.

Herman M. Somers, Ph. D., professor of politics and public affairs, Princeton University; past member of the Advisory Council on Social Security; consultant to many governmental and private agencies in the fields of administration and health services.

Nathan J. Stark, group vice president of operations, Hallmark Cards; president, Kansas City General Hospital and Medical Center Corp.

Ray E. Trussell, M.D., director, School of Public Health and Administrative Medicine, Columbia University; former commissioner of hospitals for New York City.

Adolfo Urrutia, M.D., practicing surgeon; past president of staff, Santa Rosa Medical Center, San Antonio, Tex.; fellow of the American College of Surgeons.

Carroll L. Witten, M.D., past president, American Academy of General Practice; practicing physician, Louisville, Ky.

Appendix B—Exhibit 8

Advisory Panel on Incentive Reimbursement Experimentation

(As of December 24, 1968)

Solomon, J. Axelrod, M.D., chairman, Department of Medical Care Organization, School of Public Health, University of Michigan

James Brindle, president, Health Insurance Plan of Greater New York

J. Douglas Colman, president, Associated Hospital Service of New York

Paul Densen, director, Harvard Center for Community Health and Medical Care, Boston, Mass.

Thomas W. Georges, Jr., M.D., secretary, Pennsylvania Departments of Health and Public Welfare

I. Leon Goodman, executive director, Federation of American Hospitals, Inc.

Donald R. Hayes, M.D., surgeon staff, Wesson Memorial Hospital, Springfield. Mass.

Harold Hinderer, Jr., controller, Western Province of the Daughters of Charity of St. Vincent de Paul, St. Louis, Mo.

Charles Anthony Hoffman, M.D., urologist, C. and O., St. Mary's, and Cabell Huntington Hospitals, Huntington, W. Va.

Thomas M. Jenkins, president, American Association of Homes for the Aging and practicing attorney

Lawrence E. Martin, associate director and comptroller, Massachusetts General Hospital

David R. Mosher, vice president, region III of the American Nursing Home Association, president New Fern Restorium, William and Mary Nursing Home, and Lakeview Manor, St. Petersburg, Fla.

Nora Piore, Association for the Aid of Crippled Children, New York, N.Y.
Jerome Pollack, associate dean for medical care planning and professor of economics of medicine, Harvard Medical School, Boston, Mass.
Pierre Salmon, M.D., County Department of Public Health and Welfare, San Mateo, Calif.
Lawrence T. Smedley, assistant director, Department of Social Security, AFL–CIO, Washington, D.C.
Robert E. Westlake, M.D., vice president, Blue Shield of Central New York, and clinical associate professor of internal medicine, State University of New York at Syracuse
William C. White, Jr., C.L.U., The Prudential Insurance Co. of America, Newark, N.J.

Chairman

Nathan J. Stark, group vice president of operations, Hallmark Cards, Inc., and member of the Health Insurance Benefits Advisory Council

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Appendix B—Exhibit 9

Technical Work Group on Reasonable Charge Determination Methodology

Nelson H. Cruikshank, former director, Department of Social Security, AFL–CIO and member of the Health Insurance Benefits Advisory Council
Robert D. Eilers, executive director, Leonard Davis Institute of Health Economics and professor of insurance, University of Pennsylvania
Peter Henle, Deputy Associate Commissioner, Bureau of Labor Statistics, U.S. Department of Labor
Herbert Klarman, professor of public health administration, School of Public Health, Johns Hopkins University
Don Landay, Chief, Employee Benefits Project, Bureau of Labor Statistics, U.S. Department of Labor
Frederick J. Malley, Jr., assistant vice president and director, Medicare Administration, Equitable Life Assurance Society of the United States
George W. Melcher, Jr., M.D., president, Group Health Insurance, Inc.
Jerome Pollack, associate dean for medical care planning, and professor of economics of medicine, School of Medicine, Harvard Medical School
Donald C. Riedel, associate professor of public health and research associate in sociology, Department of Epidemiology and Public Health, School of Medicine, Yale University
John A. Rowland, Secretary, committee on insurance and prepayment plans, Council on Medical Services, American Medical Association, Chicago, Ill.
Bert Seidman, director, Department of Social Security, AFL–CIO
Richard Shoemaker, assistant director, Department of Social Security, AFL–CIO
Anne R. Somers, research associate, Haverford College, and staff, Industrial Relations Section, Princeton University
Boyd Thompson, executive secretary, Foundation for Medical Care of San Joaquin County, Stockton, Calif.

Appendix B—Exhibit 10

Statement of Actuarial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program Beginning April 1968

There follows a statement of actuarial assumptions and bases employed in arriving at the amount of standard premium rate for the supplementary medical insurance program beginning April 1968. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of both the actual operating experience under the program and the results of a current continuing sample survey of beneficiaries (which gives certain information more promptly than do the aggregate operations of the program). Because of the time lag in the submission of bills in this program, complete figures for the 6 months of 1966 are not yet available, and the processed data for the first 10 months of 1967 are rather incomplete.

There are current figures for cash expenditures under the program, but these figures taken alone are misleading because they do not take into account the liabilities arising from the natural delay in benefit payments until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians and enrollees in making requests for payment, and the time required by the carriers to adjudicate and pay claims. There was a balance of $394 million in the supplementry medical insurance trust fund at the end of October 1967 (a decline from a peak of $570 million at the end of March 1967), but there were at that time substantial outstanding liabilities incurred for services rendered during the first 16 months of the program.

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures of the program for the 6 months of 1966 were $1.93; for the first 10 months of 1967, the average was $6.06. However, these figures need to be adjusted for the estimated increase in liability that took place during the period for benefits that will be paid for services rendered during the period but had not been paid at the end of the period; that is, the premium rate must be set on an accrual basis, rather than a cash basis.

Figures on an accrual basis for the 6 months of 1966 are, of course, much more complete than for 1967. On the basis of the 1966 accrual figures, it is now estimated that, for this 6-month period, benefits and administrative expenses per capita exceeded the income from premiums and matching Government contributions by 30 cents per month (that is, 15 cents each). It is further estimated that the liability of the system for the entire 1½ year period, July 1966 to December 1967, will be about 7 percent higher than the income from the premiums and the matching Government contribution. In other words, it is expected that the $3 premium for the entire period will be lower than half the cost for benefits and administrative expenses by about 20 cents. About 12 cents of this 20 cents is accounted for by the fact that apparently physicians' fees were higher during this period than had been assumed in setting the premium; the remaining 8 cents arises from the fact that there has apparently been a somewhat greater utilization of services under the program than had been anticipated. Projecting costs of the program for the 15-month period following March 1968 at the level of operation in 1966–67 thus would require an additional 20 cents in the premium rate. These estimates are based upon incomplete data for past periods and upon projections thereof and may be somewhat more or less when the final accounts are in.

In estimating the cost of the program for April 1968 through June 1969, it is necessary to provide for the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-range upward trend of the general earnings levels, which will be reflected in higher physicians' fees and administrative expenses.

It is assumed that, in 1968–69, physicians' fees will increase at an annual rate of 5 percent and utilization of medical services by enrollees will increase at an annual rate of 2 percent. Administrative expenses are assumed to represent 9½ percent of the benefit payments; this figure is based on the actual operating results in 1967, when the average per capita administrative expenses of $0.56 per month represented 9.5 percent of the average per capita benefit costs on an incurred basis. (The administrative expenses, on a paid basis, represented an average monthly per capita amount of $0.70 for the 6 months of 1966. The 1966 average was relatively high because of the necessary one-time startup costs.) The average interest rate on the invested assets of the trust is assumed to be 4¾ percent (the rate applicable to virtually the entire portfolio as of October 31, 1967).

It is estimated that the monthly per capita cost on a calendar-year basis would be $7.61 for 1968 and $8.28 for 1969 if the provisions of the 1967 amendments were in effect for this entire period. The cost for the 15-month period beginning April 1968 would average out at $7.89 a month (half of which is $3.95). Thus, a standard premium rate of $4 per month for the period April 1968 through June 1969 would allow a margin for contingencies, as required by law.

In addition, the interest earnings of the trust fund are available as a margin for contingencies and, if not needed to pay benefits and administrative expenses in the current period, will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings are the equivalent of another 10 cents per capita in available income.

The explanation of the $1 increase in the monthly premium rate for the new premium period can be summarized in the following manner:

(*a*) The cost of the protection under the program as in effect in 1966–67 is estimated to have exceeded the income from premiums and Government matching contribution by about 7 percent—an increase of about 20 cents.

(*b*) The cost of the program in 1966–67 was abnormally low as a result of the fact that in the 6 months of operation in 1966 the full $50 deductible was applicable, and it had a much stronger effect in reducing benefit costs than will be the case in later years; in other words, with all other things being the same, the program cost is higher for future years, in which the $50 deductible is usually applicable for 12-month periods, than for the initial period—an increase of about 3 cents.

(*c*) The $50 deductible represents a smaller proportion of the total covered medical charges when these increase as a result of either higher physician fees or higher utilization—an increase of about 11 cents.

(*d*) the utilization of medical services is assumed to be higher in the new premium period than in 1966–67, and so the program cost is higher—an increase of about 11 cents.

(*e*) The level of physicians' fees is assumed to be higher in the new premium period than in 1966–67, and so the program cost is higher—an increase of about 27 cents.

(*f*) The increased benefit protection arising from the provisions of the 1967 amendments must be taken into account—an increase of about 23 cents.

(*g*) The promulgated rate includes an amount to provide a margin for contingencies—an increase of 5 cents.

As indicated previously, the program has more than ample funds, on a cash basis, to meet its expected obligations for benefit payments and administrative expenses now and in the period to which the promulgated premium rate applies.

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68); Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

TOTALS–All Categories

BENEFICIARIES[1]	HEALTH CARE RESOURCES
• Hospital Insurance– 19,696,747	• Hospitols[2]–6,865 (Generol[3]–6,406; PSYCH.–341; TB–118) Generol Beds–822,132 (Per 1,000 beneficiaries–41.9)
• Medical Insurance– 18,797,760 "Buy-in"–1,574,026 (Percent of total– 11.9%)	• Extended Core Facilities–4,702 Beds[4]–329,621 (Per 1,000 beneficiaries– 16.8)
	• Home Health Agencies– 2,093
	• Independent Labaratories– 2,566
	• Rehab. Agencies, Clinics and Public Health Agencies– 55
	• Suppliers of Partoble X-ray Services– 140
BENEFITS PAID	**ADMISSIONS AND STARTS OF CARE**
• Hospital Insurance–$3,736,000,000	• Inpatient Hospital Admissians–5,655,100 (Per 1,000 beneficiaries–291)
• Medical Insurance–$1,390,000,000	• Extended Care Facility Admissians–448,500 (Per 1,000 beneficiories– 23)
	• Home Health Starts of Care[5]–258,100 (Per 1,000 beneficiories–13.2)
	• Emergency Hospital Claims Processed–25,361

[1] Bosed on data recarded as of October 3, 1968.

[2] Includes 4 Federal haspitals; excludes 18 Christian Science sanatoriums.

[3] Short-stay and long-stay hospitals. Includes separately certified medicol and surgicol units and beds of psychiatric and tuberculasis hospitals not accredited by the Joint Commissian an Accreditatian af Hospitals or the American Osteapathic Assaciotian.

[4] Includes skilled nursing beds anly.

[5] Includes home health start af care notices fram both hospital insurance and medical insurance.

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

ALABAMA

BENEFICIARIES

- Hospital Insurance– 312,549
- Medical Insurance– 297,417
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 118 General– 116; PSYCH.– 1; TB– 1
  General Beds– 11,553 Per 1,000 beneficiaries– 37.1
- Extended Care Facilities– 94
  Beds– 5,984 Per 1,000 beneficiaries– 19.2
- Home Health Agencies– 35
- Independent Laboratories– 11

BENEFITS PAID

- Hospital Insurance– $ 43,593,281
- Medical Insurance– $ 15,730,690

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 93,500 Per 1,000 beneficiaries–300
- Extended Care Facility Admissions– 4,700 Per 1,000 beneficiaries– 15.1
- Home Health Starts of Care– 2,500 Per 1,000 beneficiaries– 8.0
- Emergency Hospital Claims Processed– 1,801

ALASKA

BENEFICIARIES

- Hospital Insurance– 6,192
- Medical Insurance– 5,017
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 21 General– 20; PSYCH.– 1; TB– 0
  General Beds– 707 Per 1,000 beneficiaries–117.2
- Extended Care Facilities– 6
  Beds– 132 Per 1,000 beneficiaries– 21.9
- Home Health Agencies– 1
- Independent Laboratories– 2

BENEFITS PAID

- Hospital Insurance– $ 571,655
- Medical Insurance– $ 237,420

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 1,500 Per 1,000 beneficiaries–250
- Extended Care Facility Admissions– 100 Per 1,000 beneficiaries– 16.7
- Home Health Starts of Care–33 Per 1,000 beneficiaries– 6.0
- Emergency Hospital Claims Processed– 0

ARIZONA

BENEFICIARIES

- Hospital Insurance– 135,594
- Medical Insurance– 129,880
  "Buy-in"– 11,398
  (Percent of total– 8.8%)

HEALTH CARE RESOURCES

- Hospitals– 61 General– 57; PSYCH.– 3; TB– 1
  General Beds– 5,610 Per 1,000 beneficiaries– 42.0
- Extended Care Facilities– 41
  Beds– 2,422 Per 1,000 beneficiaries– 18.1
- Home Health Agencies– 10
- Independent Laboratories– 50

BENEFITS PAID

- Hospital Insurance– $ 31,037,336
- Medical Insurance– 13,997,530

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 44,100 Per 1,000 beneficiaries–330
- Extended Care Facility Admissions– 5,200 Per 1,000 beneficiaries– 39.0
- Home Health Starts of Care– 2,700 Per 1,000 beneficiaries– 20.2
- Emergency Hospital Claims Processed– 35

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

ARKANSAS

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 228,682	• Hospitals– 107 General–104 ; PSYCH.– 2 ; TB– 1
• Medical Insurance– 218,719 "Buy-in"– 62,199 (Percent of total–28.4%)	General Beds– 7,766 Per 1,000 beneficiaries– 34.1
	• Extended Care Facilities– 41 Beds– 2,498 Per 1,000 beneficiaries– 11.0
	• Home Health Agencies– 69
	• Independent Laboratories– 13
BENEFITS PAID	**ADMISSIONS AND STARTS OF CARE**
• Hospital Insurance– $ 29,767,649	• Inpatient Hospital Admissions– 81,000 Per 1,000 beneficiaries–355
• Medical Insurance– $ 10,362,073	• Extended Care Facility Admissions– 2,300 Per 1,000 beneficiaries– 10.1
	• Home Health Starts of Care– 1,300 Per 1,000 beneficiaries– 5.7
	• Emergency Hospital Claims Processed– 16

CALIFORNIA

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 1,704,836	• Hospitals– 586 General–546 ; PSYCH.–37 ; TB– 3
• Medical Insurance– 1,659,838 "Buy-in"– 292,246 (Percent of total– 17.6%)	General Beds– 69,642 Per 1,000 beneficiaries– 41.2
	• Extended Care Facilities–851 Beds– 62,246 Per 1,000 beneficiaries– 36.8
	• Home Health Agencies– 99
	• Independent Laboratories– 582
BENEFITS PAID	**ADMISSIONS AND STARTS OF CARE**
• Hospital Insurance– $411,390,472	• Inpatient Hospital Admissions– 466,600 Per 1,000 beneficiaries–276
• Medical Insurance– $202,698,487	• Extended Care Facility Admissions– 81,000 Per 1,000 beneficiaries– 47.9
	• Home Health Starts of Care–32,500 Per 1,000 beneficiaries– 19.2
	• Emergency Hospital Claims Processed– 206

COLORADO

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 183,043	• Hospitals– 89 General– 85 ; PSYCH.– 4 ; TB– 0
• Medical Insurance– 177,964 "Buy-in"– 35,555 (Percent of total– 20.0%)	General Beds– 8,955 Per 1,000 beneficiaries– 49.2
	• Extended Care Facilities– 93 Beds– 6,518 Per 1,000 beneficiaries– 35.8
	• Home Health Agencies– 19
	• Independent Laboratories– 34
BENEFITS PAID	**ADMISSIONS AND STARTS OF CARE**
• Hospital Insurance– $ 43,194,097	• Inpatient Hospital Admissions– 71,200 Per 1,000 beneficiaries–391
• Medical Insurance– $ 15,591,352	• Extended Care Facility Admissions– 6,800 Per 1,000 beneficiaries– 37.4
	• Home Health Starts of Care– 3,100 Per 1,000 beneficiaries– 17.0
	• Emergency Hospital Claims Processed– 85

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

CONNECTICUT

BENEFICIARIES

- Hospital Insurance– 280,622
- Medical Insurance– 275,078
  "Buy-in"– 7,100
  (Percent of total– 2.6%)

HEALTH CARE RESOURCES

- Hospitals– 51 General– 43; PSYCH.– 8; TB– 0
  General Beds– 10,350 Per 1,000 beneficiaries– 37.1
- Extended Care Facilities– 170
  Beds– 11,616 Per 1,000 beneficiaries– 41.6
- Home Health Agencies– 99
- Independent Laboratories– 48

BENEFITS PAID

- Hospital Insurance– $80,279,842
- Medical Insurance– $20,715,025

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 68,000 Per 1,000 beneficiaries– 243
- Extended Care Facility Admissions– 11,600 Per 1,000 beneficiaries– 41.5
- Home Health Starts of Care– 7,800 Per 1,000 beneficiaries– 27.9
- Emergency Hospital Claims Processed– 0

DELAWARE

BENEFICIARIES

- Hospital Insurance– 43,323
- Medical Insurance– 41,875
  "Buy-in"– 1,907
  (Percent of total– 4.6%)

HEALTH CARE RESOURCES

- Hospitals– 9 General– 7; PSYCH.– 1; TB– 1
  General Beds– 1,588 Per 1,000 beneficiaries– 36.8
- Extended Care Facilities– 9
  Beds– 539 Per 1,000 beneficiaries– 12.5
- Home Health Agencies– 8
- Independent Laboratories– 4

BENEFITS PAID

- Hospital Insurance– $ 7,725,495
- Medical Insurance– $ 2,903,457

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 9,600 Per 1,000 beneficiaries– 223
- Extended Care Facility Admissions– 900 Per 1,000 beneficiaries– 20.9
- Home Health Starts of Care– 1,200 Per 1,000 beneficiaries– 27.8
- Emergency Hospital Claims Processed– 0

DISTRICT OF COLUMBIA

BENEFICIARIES

- Hospital Insurance– 67,849
- Medical Insurance– 63,885
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 15 General– 13; PSYCH.– 2; TB– 0
  General Beds– 5,162 Per 1,000 beneficiaries– 76.0
- Extended Care Facilities– 7
  Beds– 1,641 Per 1,000 beneficiaries– 24.2
- Home Health Agencies– 2
- Independent Laboratories– 6

BENEFITS PAID

- Hospital Insurance– $16,498,842
- Medical Insurance– $ 7,282,147

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 21,200 Per 1,000 beneficiaries– 312
- Extended Care Facility Admissions– 700 Per 1,000 beneficiaries– 10.3
- Home Health Starts of Care– 1,800 Per 1,000 beneficiaries– 25.7
- Emergency Hospital Claims Processed– 0

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

FLORIDA

BENEFICIARIES

- Hospital Insurance– 798,864
- Medical Insurance– 777,047
  "Buy-in"– 67,599
  (Percent of total– 8.7%)

HEALTH CARE RESOURCES

- Hospitals– 175 General–167 ; PSYCH.– 6 ; TB– 2
  General Beds– 23,795 Per 1,000 beneficiaries– 30.2
- Extended Care Facilities–159
  Beds– 12,291 Per 1,000 beneficiaries– 15.6
- Home Health Agencies– 61
- Independent Labaratories–109

BENEFITS PAID

- Hospital Insurance–$165,718,417
- Medical Insurance–$ 81,931,518

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 240,600 Per 1,000 beneficiaries–305
- Extended Care Facility Admissions– 25,300 Per 1,000 beneficiaries– 32.1
- Home Health Starts of Care–10,700 Per 1,000 beneficiaries– 13.5
- Emergency Hospital Claims Processed– 779

GEORGIA

BENEFICIARIES

- Hospital Insurance– 350,026
- Medical Insurance– 335,693
  "Buy-in"– 92,067
  (Percent of total– 27.4%)

HEALTH CARE RESOURCES

- Hospitals– 145 General–138 ; PSYCH.– 6 ; TB– 1
  General Beds– 14,444 Per 1,000 beneficiaries– 41.4
- Extended Care Facilities– 77
  Beds– 6,012 Per 1,000 beneficiaries– 17.3
- Home Health Agencies– 15
- Independent Labaratories– 20

BENEFITS PAID

- Hospital Insurance–$ 47,220,456
- Medical Insurance–$ 18,125,239

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 108,900 Per 1,000 beneficiaries–312
- Extended Care Facility Admissions– 5,800 Per 1,000 beneficiaries– 16.6
- Home Health Starts of Care– 2,100 Per 1,000 beneficiaries– 6.0
- Emergency Hospital Claims Processed– 2,174

HAWAII

BENEFICIARIES

- Hospital Insurance– 41,048
- Medical Insurance– 40,116
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 25 General– 24 ; PSYCH.– 1 ; TB– 0
  General Beds– 2,761 Per 1,000 beneficiaries– 68.5
- Extended Care Facilities– 16
  Beds– 1,081 Per 1,000 beneficiaries– 26.8
- Home Health Agencies– 2
- Independent Labaratories– 13

BENEFITS PAID

- Hospital Insurance–$ 8,793,498
- Medical Insurance–$ 3,961,668

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 12,000 Per 1,000 beneficiaries–298
- Extended Care Facility Admissions– 1,300 Per 1,000 beneficiaries– 32.3
- Home Health Starts of Care– 400 Per 1,000 beneficiaries– 9.9
- Emergency Hospital Claims Processed– 0

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

IDAHO

BENEFICIARIES

- Hospital Insurance– 66,595
- Medical Insurance– 64,056
  "Buy-in"– 5,683
  (Percent of total– 8.9%)

HEALTH CARE RESOURCES

- Hospitals– 48 General– 47 ; PSYCH.– 0 ; TB– 1
  General Beds– 2,339 Per 1,000 beneficiaries– 35.4
- Extended Care Facilities– 40
  Beds– 2,490 Per 1,000 beneficiaries– 37.7
- Home Health Agencies– 10
- Independent Laboratories– 1

BENEFITS PAID

- Hospital Insurance– $ 10,204,815
- Medical Insurance– $ 3,778,227

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 21,000 Per 1,000 beneficiaries– 318
- Extended Care Facility Admissions– 2,800 Per 1,000 beneficiaries– 42.4
- Home Health Starts of Care– 2,500 Per 1,000 beneficiaries– 37.8
- Emergency Hospital Claims Processed– 0

ILLINOIS

BENEFICIARIES

- Hospital Insurance– 1,085,039
- Medical Insurance– 1,046,334
  "Buy-in"– 40,274
  (Percent of total– 3.8%)

HEALTH CARE RESOURCES

- Hospitals– 301 General–272 ; PSYCH.– 19; TB– 10
  General Beds– 51,717 Per 1,000 beneficiaries– 47.8
- Extended Care Facilities–169
  Beds– 11,068 Per 1,000 beneficiaries– 10.2
- Home Health Agencies– 81
- Independent Laboratories–143

BENEFITS PAID

- Hospital Insurance–$235,009, 850
- Medical Insurance–$ 64,735,828

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions–309,000 Per 1,000 beneficiaries– 285
- Extended Care Facility Admissions– 22,400 Per 1,000 beneficiaries– 20.7
- Home Health Starts of Care– 9,400 Per 1,000 beneficiaries– 8.7
- Emergency Hospital Claims Processed– 0

INDIANA

BENEFICIARIES

- Hospital Insurance– 487,197
- Medical Insurance– 465,467
  "Buy-in"– 18,313
  (Percent of total– 3.9%)

HEALTH CARE RESOURCES

- Hospitals– 137 General– 123 ; PSYCH.– 9 ; TB– 5
  General Beds– 18,343 Per 1,000 beneficiaries– 37.7
- Extended Care Facilities– 67
  Beds– 5,298 Per 1,000 beneficiaries– 10.9
- Home Health Agencies– 26
- Independent Laboratories– 32

BENEFITS PAID

- Hospital Insurance–$ 81,860,976
- Medical Insurance–$ 24,899,213

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions–127,500 Per 1,000 beneficiaries– 262
- Extended Care Facility Admissions– 7,700 Per 1,000 beneficiaries– 15.8
- Home Health Starts of Care–4,500 Per 1,000 beneficiaries– 9.2
- Emergency Hospital Claims Processed– 0

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

IOWA

BENEFICIARIES

- Hospital Insurance– 352,320
- Medical Insurance– 341,567
  "Buy-in"– 23,276
  (Percent of total– 6.8%)

HEALTH CARE RESOURCES

- Hospitals– 146 General– 141; PSYCH.– 4 ; TB– 1
  General Beds– 14,113 Per 1,000 beneficiaries– 40.1
- Extended Care Facilities– 75
  Beds– 3,903 Per 1,000 beneficiaries– 11.1
- Home Health Agencies– 22
- Independent Laboratories– 16

BENEFITS PAID

- Hospital Insurance–$59,038,630
- Medical Insurance–$20,354,677

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 119,500 Per 1,000 beneficiaries– 339
- Extended Care Facility Admissions– 6,300 Per 1,000 beneficiaries– 17.9
- Home Health Starts of Care– 2,400 Per 1,000 beneficiaries– 6.8
- Emergency Hospital Claims Processed– 116

KANSAS

BENEFICIARIES

- Hospital Insurance– 263,577
- Medical Insurance– 252,967
  "Buy-in"– 22,050
  (Percent of total– 8.7%)

HEALTH CARE RESOURCES

- Hospitals– 169 General– 162; PSYCH.– 5 ; TB– 2
  General Beds– 12,627 Per 1,000 beneficiaries– 47.9
- Extended Care Facilities– 70
  Beds– 2,104 Per 1,000 beneficiaries– 8.0
- Home Health Agencies– 29
- Independent Laboratories– 24

BENEFITS PAID

- Hospital Insurance–$45,064,216
- Medical Insurance–$11,637,144

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 89,400 Per 1,000 beneficiaries– 339
- Extended Care Facility Admissions– 4,700 Per 1,000 beneficiaries– 17.8
- Home Health Starts of Care– 1,500 Per 1,000 beneficiaries– 5.7
- Emergency Hospital Claims Processed– 0

KENTUCKY

BENEFICIARIES

- Hospital Insurance– 333,403
- Medical Insurance– 322,418
  "Buy-in"– 61,096
  (Percent of total–18.9%)

HEALTH CARE RESOURCES

- Hospitals– 131 General– 119; PSYCH.– 5 ; TB– 7
  General Beds– 10,942 Per 1,000 beneficiaries– 32.9
- Extended Care Facilities– 57
  Beds– 3,673 Per 1,000 beneficiaries– 11.1
- Home Health Agencies– 15
- Independent Laboratories– 32

BENEFITS PAID

- Hospital Insurance–$48,499,531
- Medical Insurance–$14,708,869

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 108,500 Per 1,000 beneficiaries– 327
- Extended Care Facility Admissions– 6,800 Per 1,000 beneficiaries– 20.5
- Home Health Starts of Care– 2,200 Per 1,000 beneficiaries– 6.6
- Emergency Hospital Claims Processed– 430

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68); Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

LOUISANA

BENEFICIARIES

- Hospital Insurance– 292,115
- Medical Insurance– 268,647
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 121 General– 117 ; PSYCH.– 3 ; TB– 1
  General Beds– 13,356 Per 1,000 beneficiaries– 45.8
- Extended Care Facilities–103
  Beds– 6,553 Per 1,000 beneficiaries– 22.5
- Home Health Agencies– 54
- Independent Laboratories– 20

BENEFITS PAID

- Hospital Insurance– $36,809,146
- Medical Insurance– $13,940,310

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 93,700 Per 1,000 beneficiaries–321
- Extended Care Facility Admissions– 4,100 Per 1,000 beneficiaries– 14.1
- Home Health Starts of Care–2,300 Per 1,000 beneficiaries– 7.9
- Emergency Hospital Claims Processed– 3,392

MAINE

BENEFICIARIES

- Hospital Insurance– 118,454
- Medical Insurance– 115,583
  "Buy-in"– 11,729
  (Percent of total– 10.1%)

HEALTH CARE RESOURCES

- Hospitals– 63 General– 61 ; PSYCH.– 1 ; TB– 1
  General Beds– 4,418 Per 1,000 beneficiaries– 37.5
- Extended Care Facilities– 25
  Beds– 972 Per 1,000 beneficiaries– 8.2
- Home Health Agencies– 22
- Independent Laboratories– 1

BENEFITS PAID

- Hospital Insurance– $22,284,289
- Medical Insurance– $ 5,635,626

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 35,400 Per 1,000 beneficiaries–301
- Extended Care Facility Admissions– 3,000 Per 1,000 beneficiaries– 25.5
- Home Health Starts of Care–1,600 Per 1,000 beneficiaries– 13.5
- Emergency Hospital Claims Processed– 39

MARYLAND

BENEFICIARIES

- Hospital Insurance– 276,418
- Medical Insurance– 258,159
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 59 General– 49 ; PSYCH.– 9 ; TB– 1
  General Beds– 12,118 Per 1,000 beneficiaries– 44.1
- Extended Care Facilities– 52
  Beds– 4,951 Per 1,000 beneficiaries– 18.0
- Home Health Agencies– 28
- Independent Laboratories–31

BENEFITS PAID

- Hospital Insurance– $49,110,623
- Medical Insurance– $14,392,800

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 57,200 Per 1,000 beneficiaries–208
- Extended Care Facility Admissions– 5,700 Per 1,000 beneficiaries– 20.8
- Home Health Starts of Care–2,000 Per 1,000 beneficiaries– 7.2
- Emergency Hospital Claims Processed– 24

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

MASSACHUSETTS

BENEFICIARIES

- Hospital Insurance– 628,963
- Medical Insurance– 615,317
  "Buy-in"– 15,337
  (Percent of total– 2.5%)

HEALTH CARE RESOURCES

- Hospitals– 193 General– 172; PSYCH.–17 ; TB– 4
  General Beds– 31,924 Per 1,000 beneficiaries– 50.8
- Extended Care Facilities– 139
  Beds– 10,640 Per 1,000 beneficiaries– 16.9
- Home Health Agencies– 178
- Independent Laboratories– 87

BENEFITS PAID

- Hospital Insurance–$161,000,125
- Medical Insurance–$ 50,678,994

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 172,400 Per 1,000 beneficiaries– 274
- Extended Care Facility Admissions– 17,300 Per 1,000 beneficiaries– 27.5
- Home Health Starts of Care–16,200 Per 1,000 beneficiaries– 25.7
- Emergency Hospital Claims Processed– 0

MICHIGAN

BENEFICIARIES

- Hospital Insurance– 750,377
- Medical Insurance– 726,929
  "Buy-in"– 36,597
  (Percent of total– 5.0%)

HEALTH CARE RESOURCES

- Hospitals– 276 General–252 ; PSYCH.– 17; TB– 7
  General Beds– 38,089 Per 1,000 beneficiaries– 51.1
- Extended Care Facilities–139
  Beds– 12,641 Per 1,000 beneficiaries– 17.0
- Home Health Agencies– 49
- Independent Laboratories– 76

BENEFITS PAID

- Hospital Insurance–$170,292,313
- Medical Insurance–$ 46,084,671

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 208,100 Per 1,000 beneficiaries– 279
- Extended Care Facility Admissions– 13,600 Per 1,000 beneficiaries– 18.3
- Home Health Starts of Care– 9,600 Per 1,000 beneficiaries– 12.9
- Emergency Hospital Claims Processed– 0

MINNESOTA

BENEFICIARIES

- Hospital Insurance– 407.452
- Medical Insurance– 396.521
  "Buy-in"– 25,142
  (Percent of total– 6.3%)

HEALTH CARE RESOURCES

- Hospitals– 196 General– 186 ; PSYCH.– 7 ; TB– 3
  General Beds– 19,031 Per 1,000 beneficiaries– 46.9
- Extended Care Facilities–141
  Beds– 7,441 Per 1,000 beneficiaries– 18.3
- Home Health Agencies– 47
- Independent Laboratories– 12

BENEFITS PAID

- Hospital Insurance–$ 92,915,202
- Medical Insurance–$ 29,156,040

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 145,000 Per 1,000 beneficiaries– 357
- Extended Care Facility Admissions– 9,000 Per 1,000 beneficiaries– 22.2
- Home Health Starts of Care– 4,900 Per 1,000 beneficiaries– 12.1
- Emergency Hospital Claims Processed– 12

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

MISSISSIPPI

BENEFICIARIES

- Hospital Insurance– 217,047
- Medical Insurance– 194,903
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 84 General– 84 ; PSYCH.– 0 ; TB– 0
  General Beds– 5,850 Per 1,000 beneficiaries– 27.0
- Extended Care Facilities– 20
  Beds– 996 Per 1,000 beneficiaries– 4.6
- Home Health Agencies– 59
- Independent Laboratories– 9

BENEFITS PAID

- Hospital Insurance–$ 24,873,973
- Medical Insurance–$ 8,611,128

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 69,300 Per 1,000 beneficiaries–320
- Extended Care
  Facility Admissions– 1,600 Per 1,000 beneficiaries– 7.4
- Home Health Starts of Care– 700 Per 1,000 beneficiaries– 3.2
- Emergency Hospital Claims Processed– 8,935

MISSOURI

BENEFICIARIES

- Hospital Insurance– 551,089
- Medical Insurance– 528,653
  "Buy-in"– 89,124
  (Percent of total– 16.9%)

HEALTH CARE RESOURCES

- Hospitals–170 General–159 ; PSYCH.–10 ; TB– 1
  General Beds– 22,663 Per 1,000 beneficiaries– 41.2
- Extended Care Facilities– 72
  Beds– 4,867 Per 1,000 beneficiaries– 8.8
- Home Health Agencies– 32
- Independent Laboratories– 56

BENEFITS PAID

- Hospital Insurance–$ 98,312,051
- Medical Insurance–$ 34,140,558

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions–174,900 Per 1,000 beneficiaries–318
- Extended Care
  Facility Admissions– 7,700 Per 1,000 beneficiaries– 14.0
- Home Health Starts of Care– 5,100 Per 1,000 beneficiaries– 9.3
- Emergency Hospital Claims Processed– 3

MONTANA

BENEFICIARIES

- Hospital Insurance– 68,997
- Medical Insurance– 66,714
  "Buy-in"– 3,796
  (Percent of total– 5.7%)

HEALTH CARE RESOURCES

- Hospitals– 66 General– 64 ; PSYCH.– 1; TB– 1
  General Beds– 3,274 Per 1,000 beneficiaries– 47.7
- Extended Care Facilities– 33
  Beds– 1,249 Per 1,000 beneficiaries– 18.2
- Home Health Agencies– 12
- Independent Laboratories– 8

BENEFITS PAID

- Hospital Insurance–$ 14,304,743
- Medical Insurance–$ 4,417,004

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 29,000 Per 1,000 beneficiaries–423
- Extended Care
  Facility Admissions– 1,700 Per 1,000 beneficiaries– 24.8
- Home Health Starts of Care– 800 Per 1,000 beneficiaries– 11.6
- Emergency Hospital Claims Processed– 37

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

NEBRASKA

BENEFICIARIES

- Hospital Insurance– 181,597
- Medical Insurance– 174,404
  "Buy-in"– 13,114
  (Percent of total– 7.5%)

HEALTH CARE RESOURCES

- Hospitals–110 General–106 ; PSYCH.– 3 ; TB– 1
  General Beds– 7,690 Per 1,000 beneficiaries– 42.4
- Extended Care Facilities– 34
  Beds–2,618 Per 1,000 beneficiaries– 14.4
- Home Health Agencies– 5
- Independent Laboratories– 19

BENEFITS PAID

- Hospital Insurance–$ 28,036,651
- Medical Insurance–$ 10,802,943

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 60,800 Per 1,000 beneficiaries– 335
- Extended Care Facility Admissions– 2,900 Per 1,000 beneficiaries– 16.0
- Home Health Starts of Care–900 Per 1,000 beneficiaries– 5.0
- Emergency Hospital Claims Processed– 63

NEVADA

BENEFICIARIES

- Hospital Insurance– 27,344
- Medical Insurance– 26,208
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 20 General– 20 ; PSYCH.– 0 ; TB– 0
  General Beds–1,690 Per 1,000 beneficiaries– 62.9
- Extended Care Facilities– 14
  Beds– 596 Per 1,000 beneficiaries– 22.2
- Home Health Agencies– 3
- Independent Laboratories– 13

BENEFITS PAID

- Hospital Insurance–$ 7,285,396
- Medical Insurance–$ 1,777,314

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 8,600 Per 1,000 beneficiaries– 320
- Extended Care Facility Admissions– 900 Per 1,000 beneficiaries– 33.5
- Home Health Starts of Care–400 Per 1,000 beneficiaries– 14.9
- Emergency Hospital Claims Processed–0

NEW HAMPSHIRE

BENEFICIARIES

- Hospital Insurance– 79,585
- Medical Insurance– 76,038
  "Buy-in"– 4,173
  (Percent of total– 5.5%)

HEALTH CARE RESOURCES

- Hospitals– 35 General– 33 ; PSYCH.– 1 ; TB–1
  General Beds– 2,654 Per 1,000 beneficiaries– 33.6
- Extended Care Facilities– 11
  Beds– 433 Per 1,000 beneficiaries– 5.5
- Home Health Agencies– 33
- Independent Laboratories– 1

BENEFITS PAID

- Hospital Insurance–$ 12,453,359
- Medical Insurance–$ 4,239,102

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 21,800 Per 1,000 beneficiaries– 276
- Extended Care Facility Admissions– 1,100 Per 1,000 beneficiaries– 13.9
- Home Health Starts of Care–1,800 Per 1,000 beneficiaries– 22.7
- Emergency Hospital Claims Processed–0

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

NEW JERSEY

BENEFICIARIES

- Hospital Insurance– 674,450
- Medical Insurance– 659,966
  "Buy-in"– 13,256
  (Percent of total– 2.0%)

HEALTH CARE RESOURCES

- Hospitals–121 General–111 ; PSYCH.–8 ; TB–2
  General Beds–25,832 Per 1,000 beneficiaries– 38.5
- Extended Care Facilities– 80
  Beds–6,150 Per 1,000 beneficiaries– 9.2
- Home Health Agencies– 50
- Independent Laboratories–122

BENEFITS PAID

- Hospital Insurance–$121,476,298
- Medical Insurance–$ 53,928,484

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 148,800 Per 1,000 beneficiaries–222
- Extended Care
  Facility Admissions– 15,700 Per 1,000 beneficiaries– 23.4
- Home Health Starts of Care–17,000 Per 1,000 beneficiaries– 25.3
- Emergency Hospital Claims Processed– 5

NEW MEXICO

BENEFICIARIES

- Hospital Insurance– 67,399
- Medical Insurance– 60,886
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 45 General– 44 ; PSYCH.– 1 ; TB–0
  General Beds–3,187 Per 1,000 beneficiaries– 48.0
- Extended Care Facilities– 21
  Beds–1,269 Per 1,000 beneficiaries– 19.1
- Home Health Agencies– 4
- Independent Laboratories– 22

BENEFITS PAID

- Hospital Insurance–$ 10,794,616
- Medical Insurance–$ 4,010,109

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 20,300 Per 1,000 beneficiaries–306
- Extended Care
  Facility Admissions– 1,200 Per 1,000 beneficiaries– 18.1
- Home Health Starts of Care–800 Per 1,000 beneficiaries– 12
- Emergency Hospital Claims Processed– 153

NEW YORK

BENEFICIARIES

- Hospital Insurance– 1,952,515
- Medical Insurance– 1,890,617
  "Buy-in"– 51,198
  (Percent of total– 2.7%)

HEALTH CARE RESOURCES

- Hospitals–396 General–358 ; PSYCH.– 35; TB– 3
  General Beds–80,740 Per 1,000 beneficiaries– 41.5
- Extended Care Facilities–257
  Beds–29,584 Per 1,000 beneficiaries– 15.2
- Home Health Agencies– 130
- Independent Laboratories–233

BENEFITS PAID

- Hospital Insurance–$411,358,046
- Medical Insurance–$189,085,821

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 462,500 Per 1,000 beneficiaries– 238
- Extended Care
  Facility Admissions– 32,800 Per 1,000 beneficiaries– 16.8
- Home Health Starts of Care–33,000 Per 1,000 beneficiaries– 16.9
- Emergency Hospital Claims Processed– 818

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

NORTH CAROLINA

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 394,338	• Hospitals– 150 General– 143 ; PSYCH.– 3 ; TB– 4
• Medical Insurance– 374,428 "Buy-in"– 0 (Percent of total– 0.0%)	General Beds– 17,494 Per 1,000 beneficiaries– 44.8
	• Extended Care Facilities– 46 Beds–3,207 Per 1,000 beneficiaries– 8.2
	• Home Health Agencies– 16
	• Independent Laboratories– 11

BENEFITS PAID	ADMISSIONS AND STARTS OF CARE
• Hospital Insurance–$ 54,000,332	• Inpatient Hospital Admissions– 118,700 Per 1,000 beneficiaries–304
• Medical Insurance–$ 18,755,635	• Extended Care Facility Admissions– 4,200 Per 1,000 beneficiaries– 10.8
	• Home Health Starts of Care– 1,300 Per 1,000 beneficiaries– 3.3
	• Emergency Hospital Claims Processed– 504

NORTH DAKOTA

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 66,554	• Hospitals– 64 General– 62 ; PSYCH.– 2 ; TB– 0
• Medical Insurance– 64,216 "Buy-in"– 4,406 (Percent of total– 6.9%)	General Beds–3,749 Per 1,000 beneficiaries– 56.6
	• Extended Care Facilities– 25 Beds–1,223 Per 1,000 beneficiaries– 18.5
	• Home Health Agencies– 7
	• Independent Laboratories– 10

BENEFITS PAID	ADMISSIONS AND STARTS OF CARE
• Hospital Insurance–$ 12,917,846	• Inpatient Hospital Admissions– 29,400 Per 1,000 beneficiaries–444
• Medical Insurance–$ 4,112,444	• Extended Care Facility Admissions– 1,000 Per 1,000 beneficiaries– 15.1
	• Home Health Starts of Care–300 Per 1,000 beneficiaries– 4.5
	• Emergency Hospital Claims Processed– 1

OHIO

BENEFICIARIES	HEALTH CARE RESOURCES
• Hospital Insurance– 983,719	• Hospitals–270 General–234 ; PSYCH.– 20; TB– 16
• Medical Insurance– 942,843 "Buy-in"– 65,298 (Percent of total– 6.9%)	General Beds–42,644 Per 1,000 beneficiaries– 43.4
	• Extended Care Facilities–179 Beds–13,070 Per 1,000 beneficiaries– 13.3
	• Home Health Agencies– 98
	• Independent Laboratories–101

BENEFITS PAID	ADMISSIONS AND STARTS OF CARE
• Hospital Insurance–$181,537,197	• Inpatient Hospital Admissions– 257,600 Per 1,000 beneficiaries–262
• Medical Insurance–$ 49,500,697	• Extended Care Facility Admissions– 18,800 Per 1,000 beneficiaries– 19.1
	• Home Health Starts of Care–13,000 Per 1,000 beneficiaries– 13.2
	• Emergency Hospital Claims Processed– 1

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

OKLAHOMA

BENEFICIARIES

- Hospital Insurance– 286,463
- Medical Insurance– 277,240
  "Buy-in"– 78,001
  (Percent of total– 28.1%)

HEALTH CARE RESOURCES

- Hospitals–147 General– 143; PSYCH.– 4 ; TB– 0
  General Beds– 10,820 Per 1,000 beneficiaries– 37.9
- Extended Care Facilities– 37
  Beds– 1,494 Per 1,000 beneficiaries– 5.2
- Home Health Agencies– 55
- Independent Laboratories– 38

BENEFITS PAID

- Hospital Insurance–$ 47,090,395
- Medical Insurance–$ 23,002,309

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 104,000 Per 1,000 beneficiaries– 365
- Extended Care Facility Admissions– 4,200 Per 1,000 beneficiaries– 14.7
- Home Health Starts of Care– 2,500 Per 1,000 beneficiaries– 8.8
- Emergency Hospital Claims Processed– 127

OREGON

BENEFICIARIES

- Hospital Insurance– 217,030
- Medical Insurance– 206,279
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 90 General– 85; PSYCH.– 4 ; TB– 1
  General Beds– 7,254 Per 1,000 beneficiaries– 33.7
- Extended Care Facilities– 85
  Beds– 4,725 Per 1,000 beneficiaries– 22.0
- Home Health Agencies– 28
- Independent Laboratories– 31

BENEFITS PAID

- Hospital Insurance–$ 41,001,477
- Medical Insurance–$ 14,191,159

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 63,500 Per 1,000 beneficiaries– 295
- Extended Care Facility Admissions– 9,400 Per 1,000 beneficiaries– 43.7
- Home Health Starts of Care– 3,300 Per 1,000 beneficiaries– 15.3
- Emergency Hospital Claims Processed–141

PENNSYLVANIA

BENEFICIARIES

- Hospital Insurance– 1,252,950
- Medical Insurance– 1,204,978
  "Buy-in"– 40,271
  (Percent of total– 3.3%)

HEALTH CARE RESOURCES

- Hospitals–297 General– 266; PSYCH.– 28 ; TB– 3
  General Beds– 53,188 Per 1,000 beneficiaries– 42.5
- Extended Care Facilities– 225
  Beds– 16,397 Per 1,000 beneficiaries– 13.1
- Home Health Agencies– 125
- Independent Laboratories– 119

BENEFITS PAID

- Hospital Insurance–$218,172,282
- Medical Insurance–$ 77,578,268

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 319,900 Per 1,000 beneficiaries– 256
- Extended Care Facility Admissions– 23,200 Per 1,000 beneficiaries– 18.5
- Home Health Starts of Care– 21,600 Per 1,000 beneficiaries– 17.2
- Emergency Hospital Claims Processed– 76

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

RHODE ISLAND

BENEFICIARIES

- Hospital Insurance– 102,130
- Medical Insurance– 99,276
  "Buy-in"– 4,625
  (Percent of total– 4.7%)

HEALTH CARE RESOURCES

- Hospitals– 21 General– 18 ; PSYCH.– 3 ; TB– 0
  General Beds– 4,601 Per 1,000 beneficiaries– 45.2
- Extended Care Facilities– 22
  Beds– 1,087 Per 1,000 beneficiaries– 10.7
- Home Health Agencies– 19
- Independent Labaratories– 17

BENEFITS PAID

- Hospital Insurance–$ 20,106,326
- Medical Insurance–$ 6,720,082

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissians– 22,700 Per 1,000 beneficiaries– 223
- Extended Care Facility Admissions– 1,800 Per 1,000 beneficiaries– 17.7
- Home Health Starts of Care– 3,500 Per 1,000 beneficiaries– 34.3
- Emergency Hospital Claims Pracessed– 1

SOUTH CAROLINA

BENEFICIARIES

- Hospital Insurance– 183,425
- Medical Insurance– 174,045
  "Buy-in"– 21,669
  (Percent of tatal–12.5%)

HEALTH CARE RESOURCES

- Hospitals– 72 General– 69 ; PSYCH.– 3 ; TB– 0
  General Beds– 7,529 Per 1,000 beneficiaries– 41.3
- Extended Care Facilities– 51
  Beds– 3,241 Per 1,000 beneficiaries– 17.9
- Home Health Agencies– 37
- Independent Laboratories– 6

BENEFITS PAID

- Hospital Insurance–$ 22,180,704
- Medical Insurance–$ 7,905,283

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 52,500 Per 1,000 beneficiaries– 288
- Extended Care Facility Admissions– 3,200 Per 1,000 beneficiaries– 17.6
- Home Health Starts af Care– 1,000 Per 1,000 beneficiaries– 5.5
- Emergency Hospital Claims Pracessed–2,868

SOUTH DAKOTA

BENEFICIARIES

- Hospital Insurance– 80,543
- Medical Insurance– 77,495
  "Buy-in"– 4,947
  (Percent af tatal– 6.4%)

HEALTH CARE RESOURCES

- Hospitals– 63 General– 63 ; PSYCH.– 0 ; TB– 0
  General Beds– 3,458 Per 1,000 beneficiaries– 43.0
- Extended Care Facilities– 20
  Beds– 976 Per 1,000 beneficiaries– 12.2
- Hame Health Agencies– 24
- Independent Labaratories– 4

BENEFITS PAID

- Haspital Insurance–$ 13,930,879
- Medical Insurance–$ 3,715,269

ADMISSIONS AND STARTS OF CARE

- Inpatient Haspital Admissians– 31,800 Per 1,000 beneficiaries– 396
- Extended Care Facility Admissions– 600 Per 1,000 beneficiaries– 7.5
- Hame Health Starts of Care–400 Per 1,000 beneficiaries– 5.0
- Emergency Hospital Claims Processed– 0

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68); Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

TENNESSEE

BENEFICIARIES

- Hospital Insurance– 370,807
- Medical Insurance– 357,448
  "Buy-in"– 48,137
  (Percent of total– 13.5%)

HEALTH CARE RESOURCES

- Hospitals– 153 General– 145; PSYCH.– 3 ; TB–5
  General Beds– 15,724 Per 1,000 beneficiaries– 42.6
- Extended Care Facilities– 55
  Beds–3,803 Per 1,000 beneficiaries– 10.3
- Home Health Agencies– 79
- Independent Laboratories– 27

BENEFITS PAID

- Hospital Insurance–$ 58,570,489
- Medical Insurance–$ 20,165,013

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 126,000 Per 1,000 beneficiaries– 341
- Extended Care Facility Admissions– 7,200 Per 1,000 beneficiaries– 19.5
- Home Health Starts of Care– 3,100 Per 1,000 beneficiaries– 8.4
- Emergency Hospital Claims Processed– 457

TEXAS

BENEFICIARIES

- Hospital Insurance– 934,888
- Medical Insurance– 908,590
  "Buy-in"– 230,976
  (Percent of total– 25.4%)

HEALTH CARE RESOURCES

- Hospitals– 535 General– 523 ; PSYCH.– 7 ; TB–5
  General Beds–42,564 Per 1,000 beneficiaries– 45.7
- Extended Care Facilities–289
  Beds–19,628 Per 1,000 beneficiaries– 21.1
- Home Health Agencies– 32
- Independent Laboratories–178

BENEFITS PAID

- Hospital Insurance–$171,366,868
- Medical Insurance–$ 71,030,[illegible]

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 340,700 Per 1,000 beneficiaries–375
- Extended Care Facility Admissions– 23,200 Per 1,000 beneficiaries– 24.8
- Home Health Starts of Care–5,500 Per 1,000 beneficiaries– 5.9
- Emergency Hospital Claims Processed– 1,380

UTAH

BENEFICIARIES

- Hospital Insurance– 72,856
- Medical Insurance– 70,126
  "Buy-in"– 3,427
  (Percent of total– 4.9%)

HEALTH CARE RESOURCES

- Hospitals– 36 General– 35 ; PSYCH.–1 ; TB–0
  General Beds–3,183 Per 1,000 beneficiaries– 44.1
- Extended Care Facilities– 29
  Beds–1,499 Per 1,000 beneficiaries– 20.8
- Home Health Agencies– 9
- Independent Laboratories– 12

BENEFITS PAID

- Hospital Insurance–$ 10,664,436
- Medical Insurance–$ 4,331,900

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 19,600 Per 1,000 beneficiaries– 272
- Extended Care Facility Admissions– 2,000 Per 1,000 beneficiaries– 27.7
- Home Health Starts of Care– 800 Per 1,000 beneficiaries– 11.1
- Emergency Hospital Claims Processed– 2

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

VERMONT

BENEFICIARIES

- Hospital Insurance– 48,668
- Medical Insurance– 47,411
  "Buy-in"– 4,218
  (Percent of total– 8.9%)

HEALTH CARE RESOURCES

- Hospitals–23 General–20 ; PSYCH.– 2 ; TB– 1
  General Beds–1,877 Per 1,000 beneficiaries– 38.7
- Extended Care Facilities–11
  Beds–447 Per 1,000 beneficiaries– 9.2
- Home Health Agencies– 10
- Independent Laboratories– 4

BENEFITS PAID

- Hospital Insurance–$ 7,665,274
- Medical Insurance–$ 2,736,188

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 14,700 Per 1,000 beneficiaries– 303
- Extended Care
  Facility Admissions– 400 Per 1,000 beneficiaries– 8.2
- Home Health Starts of Care–800 Per 1,000 beneficiaries– 16.5
- Emergency Hospital Claims Processed– 30

VIRGINIA

BENEFICIARIES

- Hospital Insurance– 347,935
- Medical Insurance– 329,603
  "Buy-in"– 10,637
  (Percent of total– 3.2%)

HEALTH CARE RESOURCES

- Hospitals–119 General–108 ; PSYCH.– 7 ; TB– 4
  General Beds– 15,864 Per 1,000 beneficiaries– 46.0
- Extended Care Facilities– 51
  Beds–3,738 Per 1,000 beneficiaries– 10.8
- Home Health Agencies– 129
- Independent Laboratories– 20

BENEFITS PAID

- Hospital Insurance–$ 51,981,990
- Medical Insurance–$ 19,140,729

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 93,400 Per 1,000 beneficiaries– 271
- Extended Care
  Facility Admissions– 5,600 Per 1,000 beneficiaries– 16.2
- Home Health Starts of Care– 2,800 Per 1,000 beneficiaries– 8.1
- Emergency Hospital Claims Processed– 74

WASHINGTON

BENEFICIARIES

- Hospital Insurance– 312,158
- Medical Insurance– 302,972
  "Buy-in"– 34,239
  (Percent of total–11.3%)

HEALTH CARE RESOURCES

- Hospitals–124 General–116 ; PSYCH.– 6 ; TB–2
  General Beds–10,800 Per 1,000 beneficiaries– 34.8
- Extended Care Facilities–167
  Beds– 8,409 Per 1,000 beneficiaries– 27.1
- Home Health Agencies– 25
- Independent Laboratories– 57

BENEFITS PAID

- Hospital Insurance–$ 64,054,865
- Medical Insurance–$ 21,050,165

ADMISSIONS AND STARTS OF CARE

- Inpatient
  Hospital Admissions– 96,300 Per 1,000 beneficiaries– 310
- Extended Care
  Facility Admissions– 16,600 Per 1,000 beneficiaries– 53.4
- Home Health Starts of Care–4,100 Per 1,000 beneficiaries– 13.2
- Emergency Hospital Claims Processed– 72

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

WEST VIRGINIA

BENEFICIARIES

- Hospital Insurance– 195,233
- Medical Insurance– 187,925
  "Buy-in"– 11,688
  (Percent of total– 6.2%)

HEALTH CARE RESOURCES

- Hospitals– 83 General– 77 ; PSYCH.–5 ; TB–1
  General Beds– 8,176 Per 1,000 beneficiaries– 42.0
- Extended Care Facilities– 27
  Beds–1,195 Per 1,000 beneficiaries– 6.1
- Home Health Agencies– 21
- Independent Laboratories– 8

BENEFITS PAID

- Hospital Insurance–$ 28,532,606
- Medical Insurance–$ 9,984,867

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 65,700 Per 1,000 beneficiaries– 337
- Extended Care Facility Admissions– 2,100 Per 1,000 beneficiaries– 10.8
- Home Health Starts of Care– 1,600 Per 1,000 beneficiaries– 8.2
- Emergency Hospital Claims Processed– 124

WISCONSIN

BENEFICIARIES

- Hospital Insurance– 465,725
- Medical Insurance– 452,412
  "Buy-in"– 7,038
  (Percent of total– 1.6%)

HEALTH CARE RESOURCES

- Hospitals– 188 General– 167 ; PSYCH.– 12; TB–9
  General Beds–19,389 Per 1,000 beneficiaries– 41.9
- Extended Care Facilities–184
  Beds–12,397 Per 1,000 beneficiaries– 26.8
- Home Health Agencies– 58
- Independent Laboratories– 17

BENEFITS PAID

- Hospital Insurance–$ 91,729,763
- Medical Insurance–$ 25,193,239

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions–143,800 Per 1,000 beneficiaries–310
- Extended Care Facility Admissions– 9,900 Per 1,000 beneficiaries– 21.4
- Home Health Starts of Care– 6,100 Per 1,000 beneficiaries– 13.2
- Emergency Hospital Claims Processed– 4

WYOMING

BENEFICIARIES

- Hospital Insurance– 30,261
- Medical Insurance– 28,926
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals– 29 General– 28 ; PSYCH.–1 ; TB– 0
  General Beds–1,483 Per 1,000 beneficiaries– 49.2
- Extended Care Facilities– 10
  Beds– 341 Per 1,000 beneficiaries– 11.3
- Home Health Agencies– 8
- Independent Laboratories– 3

BENEFITS PAID

- Hospital Insurance–$ 4,917,784
- Medical Insurance–$ 1,636,257

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 11,200 Per 1,000 beneficiaries–372
- Extended Care Facility Admissions– 400 Per 1,000 beneficiaries– 13.3
- Home Health Starts of Care–300 Per 1,000 beneficiaries– 9.9
- Emergency Hospital Claims Processed–28

APPENDIX C

Beneficiaries and Participating Health Care Resources (as of 7/1/68);
Benefits Paid, Admissions and Home Health Starts of Care (7/1/67–6/30/68)

PUERTO RICO

BENEFICIARIES

- Hospital Insurance– 154,765
- Medical Insurance– 91,801
  "Buy-in"– 0
  (Percent of total– 0.0%)

HEALTH CARE RESOURCES

- Hospitals–105 General– 97 ; PSYCH.– 3 ; TB–5
  General Beds– 6,855 Per 1,000 beneficiaries– 45.2
- Extended Care Facilities– 5
  Beds– 245 Per 1,000 beneficiaries– 1.6
- Home Health Agencies– 2
- Independent Labaratories– 52

BENEFITS PAID

- Hospital Insurance–$ 8,749,594
- Medical Insurance–$ 4,290,769

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions–32,300 Per 1,000 beneficiaries– 213
- Extended Care Facility Admissions– 130 Per 1,000 beneficiaries– 0.8
- Home Health Starts of Care– 300 Per 1,000 beneficiaries– 2.0
- Emergency Hospital Claims Processed– 93

VIRGIN ISLANDS, GUAM AND AMERICAN SAMOA

BENEFICIARIES

- Hospital Insurance– 4,220
- Medical Insurance– 3,021
  "Buy-in"– 223
  (Percent of total– 7.4%)

HEALTH CARE RESOURCES

- Hospitals– 7 General– 7 ; PSYCH.–0 ; TB–0
  General Beds– 550 Per 1,000 beneficiaries– 130.3
- Extended Care Facilities– 1
  Beds– 550 Per 1,000 beneficiaries– 5.5
- Home Health Agencies– 2
- Independent Laboratories– 1

BENEFITS PAID

- Hospital Insurance–$ 314,868
- Medical Insurance– 30,214

ADMISSIONS AND STARTS OF CARE

- Inpatient Hospital Admissions– 1,000 Per 1,000 beneficiaries– 240
- Extended Care Facility Admissions– 7 Per 1,000 beneficiaries– 2.0
- Home Health Starts of Care– 85 Per 1,000 beneficiaries– 20
- Emergency Hospital Claims Processed– 0

APPENDIX D
Exhibit 1

DISTRIBUTION OF ENROLLEES AND CHARGES UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, BY DEDUCTIBLE STATUS, JANUARY–DECEMBER, 1967

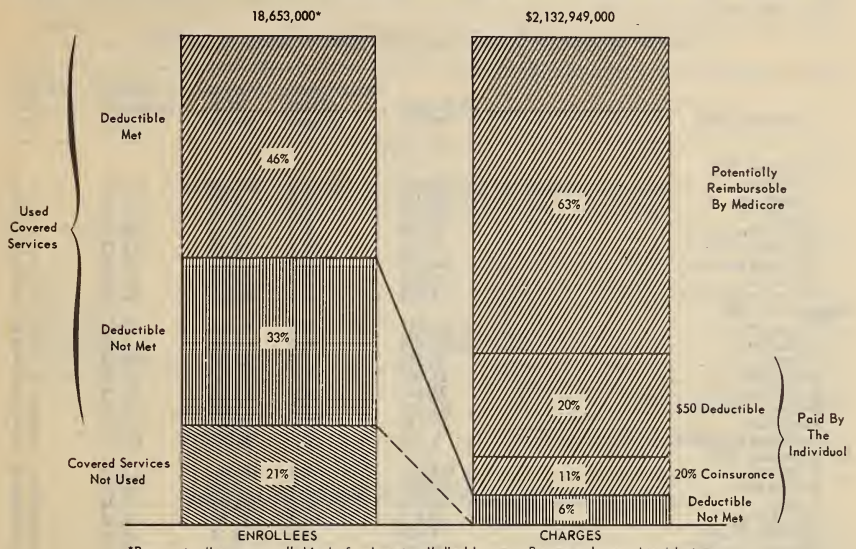

EXHIBIT 2

[Current medicare survey, medical insurance sample: Estimated 12-month cumulative number and percentage distribution of medical insurance enrollees, by selected characteristics and use of covered medical services, January-December 1967 [1]]

Characteristic	Total	Enrollees not using services	Enrollees using covered services		
			Total [2]	$50 deductible not met	$50 deductible met
Total number [3] (in thousands)	18,653	3,890	14,763	5,849	8,551
Percentage distribution:					
All persons	100.0	20.9	79.1	31.4	45.8
65 to 74	100.0	22.7	77.3	31.8	43.5
75 to 84	100.0	18.6	81.4	31.7	47.8
85 and over	100.0	15.4	84.6	25.6	57.4
Sex:					
Men	100.0	24.9	75.1	29.0	43.7
Women	100.0	17.8	82.2	33.2	47.5

[1] Represents the status of medical insurance enrollees by the end of the 12-month period, Jan. 1-Dec. 31, 1967, with respect to their use of covered medical services and meeting the $50 deductible.
[2] Includes persons using services for which a bill is not expected.
[3] Represents all persons enrolled in the supplementary medical insurance program and exposed to risk at any time during the 12-month period. Included are all persons aging into the program and all deaths and terminations during this period, regardless of month of occurrence.

Appendix D

EXHIBIT 3.—NUMBER AND PERCENT OF SERVICES WHERE ALLOWED CHARGE LESS THAN TOTAL CHARGE AND PERCENT REDUCTION FROM AVERAGE TOTAL TO AVERAGE ALLOWED CHARGE BY TYPE AND DATE OF SERVICE JULY 1966–JUNE 1968

[Preliminary data based on 5 percent sample bills processed through August 1968]

Type of service	Number of services	Percent where charge reduced	Average total charge	Average reasonable charge	Percent reduction
July–December 1966:					
All services	2,292,547	3.9	$11.59	$11.31	2.4
Medical care	1,806,118	3.8	6.82	6.68	2.1
Surgery	67,451	6.9	136.10	131.76	3.2
Consultation	23,490	6.8	20.15	19.24	4.5
Diagnostic X-ray	77,852	3.2	14.74	14.49	1.7
Diagnostic laboratory	246,973	3.2	5.42	5.32	1.9
Anesthesia	16,617	7.0	56.48	55.32	2.1
Assistance at surgery	4,935	6.4	60.47	58.35	3.5
January–June 1967:					
All services	2,813,292	4.2	11.15	10.84	2.8
Medical care	2,202,416	4.0	6.96	6.80	2.3
Surgery	73,988	7.6	131.08	126.29	3.7
Consultation	28,667	8.1	21.42	20.32	5.1
Diagnostic X-ray	95,640	3.1	14.53	14.29	1.7
Diagnostic laboratory	328,165	3.5	5.44	5.32	2.2
Anesthesia	17,143	7.8	58.64	57.25	2.4
Assistance at surgery	5,235	9.0	65.70	62.17	5.4
July–December 1967:					
All services	2,415,619	4.9	10.54	10.23	3.0
Medical care	1,897,582	4.8	7.00	6.82	2.6
Surgery	56,912	8.8	120.47	115.94	3.8
Consultation	25,815	10.8	21.56	20.23	6.2
Diagnostic X-ray	77,430	4.2	14.32	13.99	2.3
Diagnostic laboratory	286,236	4.6	5.50	5.35	2.7
Anesthesia	11,854	10.7	58.18	56.26	3.3
Assistance at surgery	3,668	11.6	66.69	63.02	5.5
January–June 1968: [1]					
All services	856,149	6.4	12.29	11.90	3.2
Medical care	664,925	6.2	7.67	7.46	2.7
Surgery	21,865	11.4	143.22	137.98	3.7
Consultation	9,603	13.2	24.11	22.52	6.6
Diagnostic X-ray	33,385	5.6	14.45	14.05	2.8
Diagnostic laboratory	95,879	6.5	5.93	5.70	3.9
Anesthesia	5,425	13.4	62.90	60.55	3.7
Assistance at surgery	1,855	11.9	65.10	61.74	5.2

[1] Because of delays associated with submittal of bills to carriers by physicians and beneficiaries, and because of normal lags in carrier and SSA processing, the tabulated figures represent a far smaller proportion of all services rendered in the first half of 1968 than do the bills for the last half of 1967. In fact, the services tabulated for 1968 represent only 30 to 35 percent of the services tabulated for earlier periods. These data are being retabulated. It is expected that the figures for 1968 will change more substantially than those for earlier periods although the trend is not likely to change.

Special Study by Selected Carriers of Physicians Receiving Medicare Reimbursement Exceeding $50,000 Annually

The following data is based on the replies received from carriers in response to our letter of November 21, 1968, requesting information regarding physicians who are receiving substantially greater than average amounts from the program's funds.

Available records received by SSA from the carriers indicated that there were 47 physicians who received substantially greater than average amounts from the program fund. Reimbursement to these physicians was made by 10 carriers. These carriers are: The Prudential Insurance Co. of America; Group Health Insurance, Inc.; Pennsylvania Blue Shield; John Hancock Mutual Life Insurance Co.; Blue Cross-Blue Shield of Alabama; Blue Shield of Florida, Inc.; Mutual of Omaha; Group Medical & Surgical Service; California Blue Shield; and Occidental Life.

Preliminary reports have been received from the carriers on all 47 physicians. The carriers to date have indicated that payments to 13 of the physicians were proper (this number will undoubtedly increase as final reports are received) and further development is being conducted on 34 of the physicians.

Exhibit No. 1 shows a breakdown of the physicians by specialty as well as the percentage of each specialty to the total specialties involved.

Exhibit No. 2 shows, by carrier, the number of physicians and a summary of the status of the carrier's development.

Exhibit No. 3 provides data by physician as well as the carrier's findings to date.

EXHIBIT 4

SUMMARY OF PHYSICIAN SPECIALIZATION BY NUMBER AND PERCENT

Specialization	Number	Percent
Urology	12	25.6
Internal medicine	12	25.6
General practice	10	21.2
General surgery	7	14.9
Ophthalmology	4	8.5
Cardiovascular disease	1	2.1
Neurological surgery	1	2.1
Total	47	100.0

EXHIBIT 5

SUMMARY OF NUMBER OF PHYSICIANS AND CARRIER ACTION

Carrier	Number of physicians	Carrier determined reimbursement proper	Carrier review not yet completed
The Prudential Life Insurance Company of America (New Jersey)	12	5	7
Group Health Insurance, Inc. (New York)	2		2
Pennsylvania Blue Shield	4		4
John Hancock Mutual Life Insurance Co. (Georgia)	2	2	
Alabama Blue Shield	2	2	
Blue Shield of Florida	18		18
Mutual of Omaha Insurance Co. (Nebraska)	1	1	
Group Medical and Surgical Service (Texas)	3	1	2
Occidental Life Insurance Company of California	1	1	
California Blue Shield	2	1	1

EXHIBIT 6

SPECIAL STUDY BY SELECTED CARRIERS OF PHYSICIANS RECEIVING MEDICARE REIMBURSEMENT EXCEEDING $50,000 ANNUALLY

Carrier and number of physicians	Annual payment rate	Specialty	Carrier determined reimbursement proper	Carrier review not yet completed	Other
Prudential (New Jersey) (12):					
1	$51,000	Urology	X		A
2	52,000	Urology	X		
3	53,000	Internal medicine		X	
4	55,000	Internal medicine		X	
5	61,000	General practice		X	
6	64,000	Urology	X		
7	69,000	Urology	X		
8	74,000	Urology	X		
9	79,000	Internal medicine		X	B
10	95,000	Urology		X	
11	118,000	General practice		X	C
12	133,000	General practice		X	C
GHI (New York) (2):					
13	54,000	Internal medicine		X	
14	67,000	Internal medicine		X	
Pennsylvania BS (4):					
15	51,000	Internal medicine		X	
16	58,000	Urology		X	
17	60,000	General practice		X	
18	74,000	Internal medicine		X	
John Hancock (Georgia) (2):					
19	65,000	General surgery	X		
20	131,000	General surgery	X		
Alabama BS (2):					
21	51,000	General practice	X		
22	76,000	Ophthalmology	X		
BS of Florida (18):					
23	50,000	Internal medicine		X	
24	50,000	Neurological surgery		X	
25	52,000	Internal medicine		X	
26	53,000	Internal medicine		X	
27	54,000	Internal medicine		X	
28	54,000	General practice		X	
29	55,000	General practice		X	
30	63,000	Urology		X	
31	69,000	Internal medicine		X	
32	84,000	Ophthalmology		X	
33	94,000	General surgery		X	
34	120,000	General practice		X	
35	132,000	Urology		X	
36	191,000	General practice		X	
37	63,000	General practice		X	
38	63,000	General surgery		X	
39	63,000	Urology		X	
40	73,000	Cardiovascular disease		X	
Mutual of Omaha (1):					
41	55,000	Urology	X		
Group Medical and Surgical (Texas) (3):					
42	63,000	General surgery		X	
43	78,000	General surgery		X	D
44	99,000	Ophthalmology	X		
California BS (2):					
45	50,000	Ophthalmology		X	
46	54,000	Urology	X		
Occidental (Calif.)(1):					
47	63,000	General surgery	X		E

A Carrier manually screens the physician's claims.

B Referred to county medical society which concluded that services billed for were rendered but there was overutilization of physician services. Charges for services above customary fees for community and the number of visits, tests, and diagnostic workups paid for, cut back.

C 2 physicians operating an extended care facility. Their claims have been reviewed carefully for some time because of certain utilization patterns.

D Physician's claims have been under close scrutiny since the early stages of the program. Because of this, payment for certain surgical activities has been curtailed.

E Despite favorable profile, the carrier will review 5 percent of all claims processed through the computer system for this physician for the months of October, November, and December 1968.

Appendix E. Publications Relating to Medicare

Exhibit:

Exhibit 1

Selected Medicare Publications

*U.S. Social Security Administration, Bureau of Health Insurance: "Directory of Providers of Services" No. 1, hospitals, No. 2, extended care facilities, No. 3, home health agencies, No. 4, independent laboratories, 1968.

*U.S. Social Security Administration, Office of Research and Statistics: "Health Insurance Enrollment Under Social Security, July 1966." Number of persons by State and County, July 1, 1966.

Notes for the Office Assistant (SSI–18): Short explanation of medical insurance payment methods and instructions for completing part B claims forms. Prepared primarily for use by the physician's office assistant.

*Financing Your Social Security Benefits (SSI–36): Explains how each program is financed: retirement, survivors, disability, and health insurance.

How to Claim Benefits under Medical Insurance (SSI–37): Explains the two methods of payment for medical expenses and tells how much Medicare will pay. Available in Spanish, SSI–37SP.

The $50 Annual Deductible Under the Medical Insurance Part of Medicare (SSI–38): Explains what the deductible is and how it works under medical insurance. Available in Spanish, SSI–38SP.

When You Enter a Hospital—How Does Medicare Help? (SSI–39): Explains Medicare benefits for hospital inpatients. Available in Spanish, SSI–39SP.

Outpatient Hospital Benefits (SSI–40): Explains benefits and methods of payment for outpatient services. Available in Spanish, SSI–40SP.

Medicare Benefits for Services in an Extended Care Facility (SSI–41): Explains what services are covered in extended care facilities and the conditions under which they are covered. Available in Spanish, SSI–41SP.

Home Health Benefits Under Medicare (SSI–42): Explains what is meant by home health services, what services are covered, and the conditions for coverage under both hospital and medical insurance. Available in Spanish, SSI–42SP.

*A Brief Explanation of Medicare—Health Insurance for People 65 or Over (SSI–43): An explanation of benefits available under both parts of Medicare. Available in Spanish, SSI–43SP.

*Your Medicare Handbook (SSI–50): A detailed explanation of Medicare provisions for beneficiaries. A copy is mailed to every beneficiary. Available in Spanish, SSI–50SP.

*Medicare—A Reference Guide for Physicians (SSI–51): A detailed explanation of the Medicare provisions prepared for use of physicians.

Coverage of Blood Under Medicare (SSI–70): Explains what the deductibles are under both part A and part B of Medicare, and how one can help to replace blood for which he might otherwise have to pay a charge. Available in Spanish, SSI–70SP.

Durable Medical Equipment Under Medicare (SSI–71): Explains what durable medical equipment is, and how Medicare helps pay for the rental or purchase of this equipment. Available in Spanish, SSI–71SP.

Limited copies of all pamphlets listed above (except the Directory of Providers of Services) are available without charge from social security district and branch offices throughout the country or from the Social Security Administration, Baltimore, Md. 21235.

*These pamphlets may also be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Exhibit 2

Federal Health Insurance for the Aged (20 C.F.R. 405) Regulations Published in the Federal Register

Subpart and title:

A. Hospital Insurance Benefits.
B. Supplementary Medical Insurance Benefits.
C. Exclusions; Recovery of Overpayment; and Liability of a Certifying Officer.
D. Principles of Reimbursement for Provider Costs; and for Services by Hospital-Based Physicians.
E. Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians.
F. Agreements With and Functions of Providers, Intermediaries, Carriers and State Agencies.
H. Review and Hearing Under the Supplementary Medical Insurance Program.
I. Premiums for Supplementary Medical Insurance Benefits.
J. Conditions of Participation; Hospitals.
K. Conditions of Participation; Extended Care Facilities.
L. Conditions of Participation; Home Health Agencies.
M. Conditions for Coverage of Services of Independent Laboratories.
N. Conditions for Coverage of Portable X-Ray Services.
O. Providers of Services and Independent Laboratories; Determinations and Appeals Procedures.
P. Certification and Recertification.
Q. Conditions of Participation: Rehabilitation Agencies, Clinics and Public Health Agencies as Providers of Outpatient Physical Therapy Services.*

Exhibit 3

Publications Relating to the Financing of the Health Insurance Program

TRUST FUND REPORTS

Board of Trustees of the Federal Hospital Insurance Trust Fund annual reports issued as follows:

1966 (for fiscal year ending June 30, 1965), House Document No. 393, 89th Congress, second session; February 28, 1966.

1967 (for fiscal year ending June 30, 1966), House Document No. 64, 90th Congress, first session; February 28, 1967.

1968 (for fiscal year ending June 30, 1967), House Document No. 290, 90th Congress, second session; March 27, 1968.

Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund annual reports issued as follows:

1966 (for fiscal year ending June 30, 1965), House Document No. 394, 89th Congress, second session; February 28, 1966.

1967 (for fiscal year ending June 30, 1966), House Document No. 66, 90th Congress, first session; February 28, 1967.

1968 (for fiscal year ending June 30, 1967), House Document No. 291, 90th Congress, second session; March 27, 1968.

ACTUARIAL COST ESTIMATES

Actuarial cost estimates and summary of provisions of the old-age, survivors, and disability insurance system as modified by the Social Security Amendments of 1965, and actuarial cost estimates and summary of provisions of the hospital insurance and supplementary medical insurance systems established by such act. Committee print, Committee on Ways and Means, House of Representatives, 89th Congress, first session; July 30, 1965.

Actuarial cost estimates for the old-age, survivors, disability, and health insurance system as modified by the Social Security Amendments of 1967. Committee print, Committee on Ways and Means, House of Representatives, 90th Congress, first session; December 11, 1967.

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* Published as proposed regulations in the Federal Register, Nov. 27, 1968.

ACTUARIAL STUDIES

Myers, Robert J., "Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965." Actuarial study No. 59, U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary; January 1965.

Myers, Robert J., and Baughman, Charles B., "History of Cost Estimates for Hospital Insurance." Actuarial study No. 61, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of the Actuary; December 1966.

Bayo, Francisco, "U.S. Population Projections for OASDHI Cost Estimates." Actuarial study No. 62, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of the Actuary; December 1966.

Myers, Robert J., "Comparison of Actual Experience Under Medicare With Original Estimates, 1966–67." Actuarial study No. 44, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of the Actuary; July 1968.

MISCELLANEOUS

"Statement of Actuarial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program for the Period April 1968 Through June 1969."

NOTE.—This statement appears as app. A of this annual report.

EXHIBIT 4

ARTICLES RELATING TO MEDICARE PUBLISHED IN THE "SOCIAL SECURITY BULLETIN"

Rice, Dorothy P., and Horowitz, Loucele A., "Medical Care Price Changes in Medicare's First 2 Years," (November 1968).

Feldstein, Paul, and Waldman, Saul, "Financial Position of Hospitals in the Early Medicare Period," (October 1968).

Callahan, Wayne, and Allen, David, "Health Insurance For the Aged: Participating Independent Laboratories," (September 1968).

Reed, Louis S., "Medicare and Federal Health Benefits Programs: Their Coordination," (September 1968).

Rice, Dorothy P., and Cooper, Barbara, "National Health Expenditures, 1950–66," (April 1968).

Cohen, Wilbur J. and Ball, Robert M., "Social Security Amendments of 1967: Summary and Legislative History" (February 1968).

Myers, Robert J. and Bayo, Francisco, "Financing Basis of Old-Age, Survivors, and Disability Insurance and Health Insurance Under the 1967 Amendments" (February 1968).

Horowitz, Loucele A., "Medical Care Price Changes in Medicare's First Year" (January 1968).

Allen, David, "Health Insurance for the Aged: Participating Home Health Agencies" (September 1967).

Reed, Louis S. and Myers, Kathleen, "Health Insurance Coverage Complementary to Medicare" (August 1967).

Ball, Robert M., "Medicare's First Year" (July 1967).

Hess, Arthur E., "Medicare's Early Months: A Program Round-up" (July 1967).

Stewart, William H., M.D., "The Impact of Medicare on the Nation's Health Care Systems" (July 1967).

Rice, Dorothy P. and Horowitz, Loucele A., "Trends in Medical Care Prices" (July 1967).

Allen, David, "Health Insurance for the Aged: Participating Extended Care Facilities" (June 1967).

Division of Health Insurance Studies, Office of Research and Statistics, "Health Insurance for the Aged: Claims Reimbursed for Hospital and Medical Services" (May 1967).

Scharff, Jack, "Current Medicare Survey: The Medical Insurance Sample" (April 1967).

Division of Health Insurance Studies, Office of Research and Statistics, "Enrollment in the Health Insurance Program for the Aged" (March 1967).

West, Howard, "Health Insurance for the Aged: The Statistical Program (January 1967).
Ball, Robert M., "Health Insurance for People Aged 65 and Over: First Steps in Administration" (February 1966).
Myers, Robert J. and Bayo, Francisco, "Health Insurance, Supplementary Medical Insurance, and Old-Age, Survivors, and Disability Insurance: Financing Basis Under the 1965 Amendments" (October 1965).
Cohen, Wilbur J. and Ball, Robert M., "Social Security Amendments of 1965: Summary and Legislative History" (September 1965).

The Social Security Bulletin is the official monthly publication of the Social Security Administration. A subscription to the Bulletin may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Price: $2.75 a year in the United States, Canada, and Mexico; $3.50 in all other countries; single copies $.25.

EXHIBIT 5

MISCELLANEOUS PUBLICATIONS

U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Health Insurance for the Aged: Amounts Reimbursed by State, July 1966–December 1967," December 19, 1968 (HI–9).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Health Insurance for the Aged: Participating Independent Laboratories," July 25, 1968 (HI–8).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Variations Among States in Per Capita Benefit Payments Under Medicare, Fiscal 1967," June 24, 1968 (HI–7).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Health Insurance for the Aged: Number of Participating Health Facilities, July 1967, by State," April 8, 1968 (HI–6).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Enrollment of Aged Public Assistance Recipients in the Medical Insurance Program Under Social Security," March 11, 1968 (HI–5).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Medicare and Care of Mental Illness," March 7, 1968 (HI–4).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Number of Persons Using Medicare Services, July 1, 1966 to June 30, 1967," February 5, 1968 (HI–3).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Blood Utilization by Inpatients Under Medicare," November 30, 1967 (HI–2).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Current Data From the Medicare Program," November 20, 1967 (HI–1).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, January–June, 1968," December 31, 1968 (CMS–7).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Estimated Number of Persons Using Medicare Services, Calendar Year 1967," December 30, 1968 (CMS–6).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, October–December 1967," October 23, 1968 (CMS–5).

U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, August–September, 1967," September 25, 1968 (CMS–4).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, July, 1967," January 26, 1968 (CMS–3).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, January–June, 1967," December 15, 1967 (CMS–2).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current Medicare survey series—"Current Medicare Survey Report, October–December, 1966," July 28, 1967 (CMS–1).

Copies of these releases are available in limited quantities from the Publications Staff, Office of Research and Statistics, Social Security Administration, Room 5628, South HEW Building, Washington, D.C., 20201.

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